

HOUSE No. 931

The Commonwealth of Massachusetts

PRESENTED BY:

Gerard J. Cassidy

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 promoting high value and high quality care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Gerard J. Cassidy</i>	<i>9th Plymouth</i>	<i>1/17/2019</i>
<i>Michael D. Brady</i>	<i>Second Plymouth and Bristol</i>	<i>2/1/2019</i>
<i>Michelle M. DuBois</i>	<i>10th Plymouth</i>	<i>2/1/2019</i>

HOUSE No. 931

By Mr. Cassidy of Brockton, a petition (accompanied by bill, House, No. 931) of Gerard J. Cassidy, Michael D. Brady and Michelle M. DuBois relative to the quality of healthcare and healthcare benefits and insurance. Financial Services.

The Commonwealth of Massachusetts

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

An Act promoting high value and high quality care.

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 8 of said chapter 6D, as so appearing, is hereby amended by
2 striking out, in line 32, the words “ and (xi) ” and inserting in place thereof the following words:-
3 (xi) not less than 3 representatives of the pharmaceutical industry; (xii) at least 1 pharmacy
4 benefit manager; and (xiii).

5 SECTION 2. Said section 8 of said chapter 6D, as so appearing, is hereby further
6 amended by inserting after the word “commission”, in line 59, the first time it appears, the
7 following words:- ; and (iii) in the case of pharmacy benefit managers and pharmaceutical
8 manufacturing companies, testimony concerning factors underlying prescription drug costs and
9 price increases, the impact of manufacturer rebates, discounts and other price concessions on net
10 pricing, the availability of alternative drugs or treatments and any other matters as determined by
11 the commission.

12 SECTION 3. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is
13 hereby amended by striking out the second sentence and inserting in place thereof the following
14 sentence:- The report shall be based on the commission's analysis of information provided at the
15 hearings by providers, provider organizations, insurers, pharmaceutical manufacturing
16 companies and pharmacy benefit managers, registration data collected under section 11, data
17 collected or analyzed by the center under sections 8, 9, 10 and 10A of chapter 12C and any other
18 available information that the commission considers necessary to fulfill its duties under this
19 section as defined in regulations promulgated by the commission.

20 SECTION 4. Chapter 6D of the General Laws is hereby further amended by inserting
21 after section 15 the following 2 sections:-

22 Section 15A. (a) The commission shall develop, implement and promote an evidence-
23 based outreach and education program to support the therapeutic and cost-effective utilization of
24 prescription drugs for physicians, podiatrists, pharmacists and other health care professionals
25 authorized to prescribe and dispense prescription drugs. In developing the program, the
26 commission shall consult with physicians, podiatrists, pharmacists, nurses, private insurers,
27 hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the
28 University of Massachusetts medical school.

29 (b) The program shall arrange for physicians, podiatrists, pharmacists and nurses to
30 conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing
31 methods from behavioral science, educational theory and, where appropriate, pharmaceutical
32 industry data and outreach techniques; provided, however, that, to the extent possible, the
33 program shall inform prescribers about drug marketing that is intended to circumvent

34 competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other
35 evidence-based treatment options.

36 The program shall be designed to provide outreach to: physicians, podiatrists and other
37 health care practitioners who participate in MassHealth, the subsidized catastrophic prescription
38 drug insurance program established in section 39 of chapter 19A, other publicly-funded,
39 contracted or subsidized health care programs, academic medical centers and other prescribers.

40 The commission shall, to the extent possible, utilize or incorporate into its program other
41 independent educational resources or models proven effective in promoting high quality,
42 evidenced-based, cost-effective information regarding the effectiveness and safety of
43 prescription drugs including, but not limited to: (i) the Pennsylvania Pharmaceutical Assistance
44 Contract for the Elderly Independent Drug Information Service affiliated with Harvard
45 University; (ii) the Academic Detailing Program through the University of Vermont Larner
46 College of Medicine's Office of Primary Care and Area Health Education Centers Program; (iii)
47 the Drug Effectiveness Review Project coordinated by the Center for Evidence-based Policy at
48 Oregon Health and Science University; and (iv) the North Carolina evidence-based peer-to-peer
49 education program outreach program.

50 (c) The commission shall make an annual report, not later than March 1, 2019, on the
51 operation of the program. The report shall be made publicly available on the commission's
52 website and include information on the outreach and education components of the program,
53 revenues, expenditures and balances and savings attributable to the program in health care
54 programs funded by the commonwealth.

55 (d) The commission shall undertake a public education initiative to inform residents of
56 the commonwealth about clinical trials and drug safety information.

57 (e) The commission may establish and collect fees for subscriptions and contracts with
58 private health care payers related to this section. The commission may seek funding from
59 nongovernmental health access foundations and undesignated drug litigation settlement funds
60 associated with pharmaceutical marketing and pricing practices.

61 Section 15B. (a) The commission shall conduct an annual study of pharmaceutical
62 manufacturing companies with pipeline drugs, generic drugs or biosimilar drug products that
63 may have a significant impact on statewide health care expenditures; provided, however, that the
64 commission may issue interim studies if it deems it necessary. The commission may contract
65 with a third-party entity to implement this section.

66 (b) A pharmaceutical manufacturing company shall, provide early notice to the
67 commission for: (i) a pipeline drug; (ii) an abbreviated new drug application for generic drugs,
68 upon submission to the federal Food and Drug Administration; or (iii) a biosimilar biologics
69 license application upon the receipt of an action date from the federal Food and Drug
70 Administration. The commission shall make early notice information available to the office of
71 Medicaid or another agency, as deemed appropriate.

72 Early notice shall be submitted to the commission not later than 60 days after receipt of
73 the federal Food and Drug Administration action date or after the submission of an abbreviated
74 new drug application to the federal Food and Drug Administration action.

75 For each prescription drug product, early notice shall include a brief description of the: (i)
76 primary disease, health condition or therapeutic area being studied and the indication; (ii) route

77 of administration being studied; (iii) clinical trial comparators; and (iv) estimated year of market
78 entry. To the extent possible, information shall be collected using data fields consistent with
79 those used by the federal National Institutes of Health for clinical trials.

80 For each pipeline drug, early notice shall include whether the drug has been designated
81 by the federal Food and Drug Administration: (i) orphan drug; (ii) fast track; (iii) breakthrough
82 therapy; (iv) for accelerated approval; or (v) priority review for a new molecular entity.

83 Notwithstanding the foregoing, submissions for drugs in development that receive such a
84 designation by the federal Food and Drug Administration for new molecular entities shall be
85 provided as soon as practical upon receipt of the relevant designation.

86 (c) The commission shall assess pharmaceutical manufacturing companies for the
87 implementation of this section in a similar manner to the annual registration fees and other
88 assessments related to the annual marketing disclosure reports required under section 2A of
89 chapter 111N.

90 (d) Notwithstanding any general or special law to the contrary, information provided
91 under this section shall be protected as confidential and shall not be a public record under clause
92 Twenty-sixth of section 7 of chapter 4 or under chapter 66.

93 SECTION 5. Section 1 of chapter 12C of the General Laws, as appearing in the 2016
94 Official Edition, is hereby amended by inserting after the definition of “Patient-centered medical
95 home” the following 2 definitions:

96 “Pharmaceutical manufacturing company”, an entity engaged in the production,
97 preparation, propagation, conversion or processing of prescription drugs, directly or indirectly,

98 by extraction from substances of natural origin or independently by means of chemical synthesis
99 or by a combination of extraction and chemical synthesis or an entity engaged in the packaging,
100 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
101 “Pharmaceutical manufacturing company” shall not include a wholesale drug distributor licensed
102 under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said
103 chapter 112.

104 “Pharmacy benefit manager”, a person or entity that administers: (i) a prescription drug,
105 prescription device or pharmacist services or (ii) a prescription drug and device and pharmacist
106 services portion of a health benefit plan on behalf of a plan sponsor including, but not limited to,
107 self-insured employers, insurance companies and labor unions; provided, however, that
108 “Pharmacy benefit manager” shall include a health benefit plan that does not contract with a
109 pharmacy benefit manager and administers its own: (a) prescription drug, prescription device or
110 pharmacist services; or (b) prescription drug and device and pharmacist services portion, unless
111 specifically exempted by the center.

112 SECTION 6. Section 5 of said chapter 12C, as so appearing, is hereby amended by
113 inserting after the word “payers”, in line 11, the following words:- , pharmaceutical
114 manufacturing companies, pharmacy benefit managers.

115 SECTION 7. Said section 5 of said chapter 12C, as so appearing, is hereby further
116 amended by inserting after the word “organizations”, in line 15, the following words:- , affected
117 pharmaceutical manufacturing companies, affected pharmacy benefit managers.

118 SECTION 8. Section 7 of said chapter 12C, as so appearing, is hereby amended by
119 adding the following paragraph:-

120 To the extent that the analysis of pharmaceutical manufacturing companies and pharmacy
121 benefit managers pursuant to section 10A increases the expenses of the center, the estimated
122 increase in the center's expenses shall be fully assessed to pharmaceutical manufacturing
123 companies and pharmacy benefit managers in the same manner as the assessment under section
124 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the
125 preceding paragraph and administers either its own: (i) prescription drug, prescription device or
126 pharmacist services; or (ii) prescription drug and device and pharmacist services portion shall not
127 be subject to additional assessment under this paragraph.

128 SECTION 9. Section 10 of said chapter 12C, as so appearing, is hereby amended by
129 striking out subsection (e) and inserting in place thereof the following 2 subsections:(e) The
130 center, in consultation with the executive office of health and human services, shall develop a
131 process for reporting health care prices and related information from providers for use by
132 consumers, employers and other stakeholders. The center shall develop and periodically update a
133 list of the most common procedures and services and a list of the most common behavioral
134 health services, including outpatient and diversionary mental health and substance use disorder
135 services, based on data collected pursuant to this section and sections 8 and 9. The center shall
136 require private and public health care payers to submit the payment rates for procedures and
137 services and other information necessary for the center to determine the rate for every provider
138 with which the payer has contracted or has a compensation arrangement. The center shall make
139 the prices and related information publicly available on the consumer health information website
140 required by section 20. The center shall keep confidential all nonpublic data obtained pursuant to
141 this subsection and shall not disclose such data to any person without the consent of the provider
142 or payer that produced the data; provided, however, that the center may disclose such data in an

143 aggregated format. The center shall promulgate regulations necessary to implement this
144 subsection.

145 (f) Except as specifically provided otherwise by the center or pursuant to this chapter,
146 insurer data collected by the center pursuant to this section shall not be a public record under
147 clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

148 SECTION 10. Said chapter 12C is hereby further amended by inserting after section 10
149 the following section: Section 10A. (a) The center shall promulgate regulations necessary to
150 ensure the uniform analysis of information regarding pharmaceutical manufacturing companies
151 and pharmacy benefit managers and that enable the center to analyze: (i) year-over-year
152 wholesale acquisition cost changes; (ii) year-over-year trends in net expenditures; (iii) net
153 expenditures on subsets of brand and generic pharmaceuticals identified by the center; (iv)
154 research and development costs as a percentage of revenue, costs paid with public funds and
155 costs paid by third parties, to the extent such costs are attributable to a specific product or set of
156 products; (v) annual marketing and advertising costs, identifying costs for direct-to-consumer
157 advertising; (vi) annual profits over the most recent 5-year period; (vii) information regarding
158 trends of estimated aggregate drug rebates and other price reductions paid by a pharmaceutical
159 manufacturing company in connection with utilization of all pharmaceutical drug products
160 offered by the pharmaceutical manufacturing company; (viii) information regarding trends of
161 estimated aggregate drug rebates and other price reductions paid by a pharmacy benefit manager
162 in connection with utilization of all drugs offered through the pharmacy benefit manager; (ix)
163 information regarding pharmacy benefit manager practices in passing drug rebates or other price
164 reductions received by the pharmacy benefit manager to a private or public health care payer or
165 to the consumer; (x) information regarding discount or free product vouchers that a retail

166 pharmacy provides to a consumer in connection with a pharmacy service, item or prescription
167 transfer offer or to any discount, rebate, product voucher or other reduction in an individual's
168 out-of-pocket expenses, including co-payments and deductibles under section 3 of chapter 175H;
169 (xi) cost disparities between prices charged to purchasers in the commonwealth and purchasers
170 outside of the United States and (xii) any other information deemed necessary by the center.

171 (b) The center shall require the submission of available data and other information from
172 pharmaceutical manufacturing companies and pharmacy benefit managers including, but not
173 limited to: (i) changes in wholesale acquisition costs for prescription drug products as identified
174 by the center; (ii) aggregate, company-level and product-specific research and development to
175 the extent attributable to a specific product or products and other relevant capital expenditures
176 for the most recent year for which final audited data are available for prescription drug products
177 as identified by the center; (iii) the price paid by the manufacturer to acquire the prescription
178 drug product if not developed by the manufacturer; (iv) the 5-year history of any increases in the
179 wholesale acquisition costs; (v) annual marketing and advertising expenditures apportioned by
180 activities directed to consumers and prescribers for prescription drug products as identified by
181 the center; and (vi) a description, suitable for public release, of factors that contributed to
182 reported changes in wholesale acquisition costs for prescription drug products as identified by
183 the center.

184 (c) Except as specifically provided otherwise by the center or under this chapter, data
185 collected by the center pursuant to this section from pharmaceutical manufacturing companies
186 and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section
187 of chapter 4 or under chapter 66.

188 SECTION 11. Said chapter 12C is hereby further amended by striking out section 11, as
189 appearing in the 2016 Official Edition, and inserting in place thereof the following section:

190 Section 11. The center shall ensure the timely reporting of information required under sections 8,
191 9, 10 and 10A. The center shall notify payers, providers, provider organizations, pharmacy
192 benefit managers and pharmaceutical manufacturing companies of any applicable reporting
193 deadlines. The center shall notify, in writing, a private health care payer, provider, provider
194 organization, pharmacy benefit manager or pharmaceutical manufacturing company that it has
195 failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the
196 notice shall result in penalties. The center shall assess a penalty against a private health care
197 payer, provider, provider organization, pharmacy benefit manager or pharmaceutical
198 manufacturing company that fails, without just cause, to provide the requested information
199 within 2 weeks following receipt of the written notice required under this paragraph of up to
200 \$5,000 per week for each week of delay after the 2-week period following receipt of the written
201 notice; provided, however, that the maximum annual penalty against a private health care payer,
202 provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing
203 company under this section shall be \$200,000. Amounts collected under this section shall be
204 deposited in the Healthcare Payment Reform Fund established in section 100 of chapter 194 of
205 the acts of 2011.

206 The center shall notify the attorney general of any pharmaceutical manufacturing
207 company or pharmacy benefit manager that fails to comply with this section for further action
208 pursuant to section 11N of chapter 12 or any other law.

209 For the purposes of this section, the center may promulgate regulations to define "just
210 cause".

211 SECTION 12. Chapter 12C of the General Laws is hereby further amended by striking
212 out section 14, as so appearing, and inserting in place thereof the following section: Section 14.
213 (a)(1) The center, in consultation with the statewide advisory committee established pursuant to
214 subsection (c) shall, not later than March 1 in each even-numbered year, establish a standard set
215 of measures of health care provider quality and health system performance, hereinafter referred
216 to as the "standard quality measure set", for use in: (i) contracts between payers, including the
217 commonwealth and carriers, and health care providers, provider organizations and accountable
218 care organizations, which incorporate quality measures into payment terms, including the
219 designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health
220 care providers in the design of any health plan; (iii) consumer transparency websites and other
221 methods of providing consumer information; and (iv) monitoring system-wide performance.

222 (2) The standard quality measure set shall be used by the commonwealth and carriers in
223 contracts with health care providers to incorporate quality measures into the payment terms
224 pursuant to section 30 of chapter 32A, section 80 of chapter 118E, section 108O of chapter 175,
225 section 41 of chapter 176A, section 27 of chapter 176B, section 35 of chapter 176G, section 14
226 of chapter 176I and for assigning tiers to health care providers in tiered network plans pursuant
227 to section 11 of chapter 176J.

228 (3) The standard quality measure set shall designate: (i) core measures that shall be used
229 in contracts between payers, including the commonwealth and carriers, and health care
230 providers, including provider organizations and accountable care organizations, that incorporate
231 quality measures into payment terms, and shall meet the core criteria set by the Quality
232 Measurement Alignment Task Force; and (ii) a menu of non-core measures that may be used in
233 such contracts. The standard quality measure set shall allow for innovation and the development

234 of outcome measures. If the standard quality measure set established by the center differs from
235 the recommendations of the statewide advisory committee, the center shall issue a written report
236 detailing each area of disagreement and the rational for the center's decision.

237 (b) The center shall develop the uniform reporting of the standard quality measure set for
238 each health care provider facility, medical group or provider group in the commonwealth.

239 (c)(1) The center shall convene a statewide advisory committee which shall make
240 recommendations for the standard quality measure set to: (i) ensure consistency in the use of
241 quality measures in contracts between payers, including the commonwealth and carriers, and
242 health care providers in the commonwealth; (ii) ensure consistency in methods for the
243 assignment of tiers to providers in the design of any health plan; (iii) improve quality of care;
244 (iv) improve transparency for consumers and employers; (v) improve health system monitoring
245 and oversight by relevant state agencies; and (vi) reduce administrative burden.

246 (2) The statewide advisory committee shall consist of the secretary of health and human
247 services and the executive director of the health policy commission, or their designees, who shall
248 serve as co-chairs, and shall include the following members or their designees: executive director
249 of the center; the executive director of the Betsy Lehman center for patient safety and medical
250 error reduction; the executive director of the group insurance commission; the director of the
251 Massachusetts e-Health Institute; the secretary of elder affairs; the assistant secretary for
252 MassHealth; the commissioner of the department of public health; the commissioner of the
253 department of mental health; and 11 members who shall be appointed by the governor, 1 of
254 whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of
255 whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.,

256 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall a
257 registered nurse licensed to practice in Massachusetts who practices in a patient care setting; 1 of
258 whom shall be a representative of a labor organizations representing health care workers; 1 of
259 whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and
260 services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of
261 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of
262 Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of
263 whom shall be a representative for consumers. Members appointed to the statewide advisory
264 committee shall have experience with and expertise in health care quality measurement.

265 (3) The statewide advisory committee shall meet quarterly to develop recommendations
266 for the core measure and non-core measures to be adopted in the standard quality measure set for
267 use in: (i) contracts between payers, including the commonwealth and carriers, and health care
268 providers, provider organizations and accountable care organizations, which incorporate quality
269 measures into payment terms, including the designation of a set of core measures and a set of
270 non-core measures; (ii) assigning tiers to health care providers in the design of any health plan;
271 (iii) consumer transparency websites and other methods of providing consumer information; and
272 (iv) monitoring system-wide performance.

273 (4) In developing its recommendations for the standard quality measure set, the statewide
274 advisory committee shall incorporate nationally recognized quality measures including, but not
275 limited to recommendations from the executive office of health and human services performance
276 measurement alignment task force, measures used by the Centers for Medicare and Medicaid
277 Services, the group insurance commission, carriers and providers and provider organizations in
278 the commonwealth and other states, as well as other valid measures of health care provider

279 performance, outcomes, including patient-reported outcomes and functional status, patient
280 experience, disparities and population health. The statewide advisory committee shall consider
281 measures applicable to primary care providers, specialists, hospitals, provider organizations,
282 accountable care organizations, oral health providers and other types of providers and measures
283 applicable to different patient populations.

284 (5) The statewide advisory committee shall, not later than January 1 in each even-
285 numbered year, submit to the center its recommendations on the core measures and non-core
286 measures to be adopted, changed or updated by the center in the standard quality measure set,
287 along with a report in support of its recommendations.

288 SECTION 13. Chapter 32A of the General Laws is hereby amended by adding at the end
289 the following new section:

290 Section 28: Notwithstanding any general or special law or rule or regulation to the
291 contrary, the Group Insurance Commission and any carrier, as defined in Section 1 of Chapter
292 176O of the general laws or other entity which contracts with the Commission to provide health
293 benefits to eligible Employees and Retirees and their eligible dependents, shall provide coverage
294 for health care services through the use of telemedicine by a contracted health care provider.
295 Such health care services shall be covered to the same extent as if they were provided via in-
296 person consultation or in-person delivery. Furthermore, such health care services shall be
297 reimbursed on the same basis as the same service through in-person consultation or contact.

298 A contract that provides coverage for telemedicine services may contain a provision for a
299 deductible, copayment or coinsurance requirement for a health care service provided through
300 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,

301 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
302 services. For health care services provided through telemedicine, a health care provider shall not
303 be required to document a barrier to an in-person visit, nor shall the type of setting where
304 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
305 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
306 transmission of a patient’s medical information, such as digital images, documents, and pre-
307 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

308 SECTION 14. Chapter 32B of the General Laws, as appearing in the 2014 official
309 edition, is hereby amended by adding at the end the following new section:

310 Section 30: Notwithstanding any general or special law or rule or regulation to the
311 contrary, the Group Insurance Commission and any carrier, as defined in Section 1 of Chapter
312 176O of the general laws or other entity which contracts to provide health benefits to eligible
313 employees of the governmental unit and their eligible dependents, shall provide coverage for
314 health care services through the use of telemedicine by a contracted health care provider. Such
315 health care services shall be covered to the same extent as if they were provided via in-person
316 consultation or in-person delivery. Furthermore, such health care services shall be reimbursed on
317 the same basis as the same service through in-person consultation or contact.

318 A contract that provides coverage for telemedicine services may contain a provision for a
319 deductible, copayment or coinsurance requirement for a health care service provided through
320 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
321 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
322 services. For health care services provided through telemedicine, a health care provider shall not

323 be required to document a barrier to an in-person visit, nor shall the type of setting where
324 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
325 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
326 transmission of a patient’s medical information, such as digital images, documents, and pre-
327 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

328 SECTION 15. Section 9 of chapter 94C of the General Laws, as so appearing, is hereby
329 amended by striking the following words in lines 31-32 of paragraph (b):- “in a single dose or in
330 a quantity” and;

331 By striking in line 35 the words, “essential for the treatment of a patient” and add the
332 words, “which is for a legitimate medical purpose by a practitioner acting in the usual course of
333 his professional practice.” And;

334 By striking in lines 35-39 the words, “The amount or quantity of any controlled substance
335 dispensed under this subsection shall not exceed the quantity of a controlled substance necessary
336 for the immediate and proper treatment of the patient until it is possible for the patient to have a
337 prescription filled by a pharmacy.”

338 And by striking in line 91-93 after of paragraph € the lines “and shall be except from the
339 requirement that such dispensing be in a single dose or as necessary for immediate and proper
340 treatment under subsection (b).

341 SECTION 16. Section 19 of said chapter 94C shall be amended by inserting in line 6 of
342 paragraph (a) after the word “prescription” “or practitioner who dispenses the controlled
343 substance.”

344 SECTION 17. Section 1 of chapter 111 is hereby amended by striking out the definition
345 of “Medical peer review committee” or “committee”, and inserting in place thereof the following
346 definition:-

347 “Medical peer review committee” or “committee”, a committee of health care providers,
348 which functions to: (i) evaluate or improve the quality of health care rendered by providers of
349 health care services; (ii) determine whether health care services were performed in compliance
350 with the applicable standards of care; (iii) determine whether the costs of health care services
351 were performed in compliance with the applicable standards of care; (iv) determine whether the
352 cost of the health care services rendered were considered reasonable by the providers of health
353 services in the area; (v) determine whether a health care provider’s actions call into question
354 such health care provider’s fitness to provide health care services; or (vi) evaluate and assist
355 health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical
356 disability, mental instability or otherwise; provided further, that “medical peer review
357 committee” shall also include: (i) a committee of a pharmacy society or association that is
358 authorized to evaluate the quality of pharmacy services or the competence of pharmacists and
359 suggest improvements in pharmacy systems to enhance patient care; or (ii) a pharmacy peer
360 review committee established by a person or entity that owns a licensed pharmacy or employs
361 pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of
362 pharmacists and suggest improvements in pharmacy systems to enhance patient care.

363 SECTION 18. Said chapter 111 of the General Laws is hereby further amended by
364 inserting at the end of section 204 the following:

365 (f) The provisions of this section shall apply to any committee formed by an individual
366 health care provider, physician group practice, licensed health care facility or any combination
367 thereof to perform the duties or functions of medical peer review as set forth in section one of
368 this chapter, notwithstanding the fact that the formation of the committee is not required by law
369 or regulation or that the individual, group or facility is not solely affiliated with a public hospital
370 or licensed hospital or nursing home or health maintenance organization.

371 SECTION 19. Section 5C of Chapter 112 of the General Laws is hereby amended to read
372 as follows:

373 Section 5C. Every insurer or risk management organization which provides professional
374 liability insurance to a registered physician shall report to the board any claim or action for
375 damages for personal injuries alleged to have been caused by error, omission, or negligence in
376 the performance of such physician's professional services where such claim resulted in:

377 (a) A final judgment in any amount, provided, however, that payments made as part of a
378 disclosure, apology and early offer program, shall not be construed to be reportable to or by the
379 board against the physician, absent a determination of substandard care rendered on the part of
380 said physician; or

381 (b) A settlement in any amount, provided, however, that payments made as part of a
382 disclosure, apology and early offer program, shall not be construed to be reportable to or by the
383 board against the physician, absent a determination of substandard care rendered on the part of
384 said physician; or

385 (c) A final disposition not resulting in payment on behalf of the insured.

386 Reports shall be filed with the board no later than thirty days following the occurrence of
387 any event listed in paragraph (a), (b), or (c).

388 Such reports shall be in writing on a form prescribed by the board and shall contain the
389 following information:

390 (a) the name, address, specialty coverage, and policy number of the physician against
391 whom the claim is made; and

392 (b) name, address and age of the claimant or plaintiff; and

393 (c) nature and substance of the claim; and

394 (d) date when and place at which the claim arose; and

395 (e) the amounts paid, if any, and the date and manner of disposition, judgment,
396 settlement, or otherwise; and

397 (f) the date and reason for final disposition, if no judgment or settlement; and

398 (g) such additional information as the board shall require. No insurer or its agents or
399 employees shall be liable in any cause of action arising from reporting to the board as required in
400 this section.

401 SECTION 20. Section 118E of the General Laws, as so appearing in the 2014 Official
402 Edition, is hereby amended by inserting at the end thereof the following new section:

403 Section 13C½. Notwithstanding any general or special law or rule or regulation to the
404 contrary, the Executive Office of Health and Human Services shall provide coverage under its
405 Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral

406 health management firms and third party administrators under contract to a Medicaid managed
407 care organization or the Medicaid primary care clinician plan for health care services provided
408 through telemedicine by a contracted provider. Such health care services shall be covered to the
409 same extent as if they were provided via in-person consultation or in-person delivery. Such
410 health care services shall be reimbursed on the same basis that Medicaid and other entities
411 covered in this paragraph reimburse for in-person consultation or contact.

412 A contract that provides coverage for telemedicine services may contain a provision for a
413 deductible, copayment or coinsurance requirement for a health care service provided through
414 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
415 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
416 services. For health care services provided through telemedicine, a health care provider shall not
417 be required to document a barrier to an in-person visit, nor shall the type of setting where
418 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
419 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
420 transmission of a patient’s medical information, such as digital images, documents, and pre-
421 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

422 SECTION 21. Section 47BB of chapter 175 of the General Laws, as most recently added
423 by Section 158 of Chapter 224 of the Acts of 2012, is hereby amended by striking subsections
424 (a)-(d) and adding at the end of the existing paragraph the following new paragraph:

425 Notwithstanding any general or special law or rule or regulation to the contrary, an
426 insurer shall provide for coverage for health care services under an individual, group, or general
427 policy of accident and sickness insurance to an insured through the use of telemedicine by a

428 contracted health care provider. Such health care services shall be covered to the same extent as
429 if they were provided via in-person consultation or in-person delivery. Furthermore, such health
430 care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-
431 person delivery of the same contracted health care services.

432 A contract that provides coverage for telemedicine services may contain a provision for a
433 deductible, copayment or coinsurance requirement for a health care service provided through
434 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
435 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
436 services. For health care services provided through telemedicine, a health care provider shall not
437 be required to document a barrier to an in-person visit, nor shall the type of setting where
438 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
439 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
440 transmission of a patient’s medical information, such as digital images, documents, and pre-
441 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

442 SECTION 22. Chapter 176A of the General Laws, as appearing in the 2014 Official
443 Edition, is hereby amended by inserting at the end thereof the following new section:

444 Section 38: Notwithstanding any general or special law or rule or regulation to the
445 contrary, any contract between a subscriber and the corporation under an individual or group
446 hospital service plan shall provide for coverage for health care services to a subscriber through
447 the use of telemedicine by a contracted health care provider. Such health care services shall be
448 covered to the same extent as if they were provided via in-person consultation or in-person

449 delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate
450 for in-person consultation or in-person delivery of the same contracted health care services.

451 A contract that provides coverage for telemedicine services may contain a provision for a
452 deductible, copayment or coinsurance requirement for a health care service provided through
453 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
454 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
455 services. For health care services provided through telemedicine, a health care provider shall not
456 be required to document a barrier to an in-person visit, nor shall the type of setting where
457 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
458 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
459 transmission of a patient’s medical information, such as digital images, documents, and pre-
460 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

461 SECTION 23. Chapter 176B of the General Laws, as appearing in the 2014 Official
462 Edition, is hereby amended by inserting at the end thereof the following new section:

463 Section 25: Notwithstanding any general or special law or rule or regulation to the
464 contrary, any contract between a subscriber and the medical service corporation shall provide for
465 coverage for health care services to a subscriber through the use of telemedicine by a contracted
466 health care provider. Such health care services shall be covered to the same extent as if they
467 were provided via in-person consultation or in-person delivery. Furthermore, such health care
468 services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person
469 delivery of the same contracted health care services.

470 A contract that provides coverage for telemedicine services may contain a provision for a
471 deductible, copayment or coinsurance requirement for a health care service provided through
472 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
473 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
474 services. For health care services provided through telemedicine, a health care provider shall not
475 be required to document a barrier to an in-person visit, nor shall the type of setting where
476 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
477 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
478 transmission of a patient’s medical information, such as digital images, documents, and pre-
479 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

480 SECTION 24. Chapter 176G of the General Laws, as appearing in the 2014 Official
481 Edition, is hereby amended by inserting at the end thereof the following new section:

482 Section 33: Notwithstanding any general or special law or rule or regulation to the
483 contrary, any contract between a member and a carrier shall provide for coverage for health
484 services to a subscriber through the use of telemedicine by a contracted health care provider.
485 Such health services shall be covered to the same extent as if they were provided via in-person
486 consultation or in-person delivery. Furthermore, such health care services shall be reimbursed at
487 a rate no less than the rate for in-person consultation or in-person delivery of the same contracted
488 health care services.

489 A contract that provides coverage for telemedicine services may contain a provision for a
490 deductible, copayment or coinsurance requirement for a health care service provided through
491 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,

492 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
493 services. For health care services provided through telemedicine, a health care provider shall not
494 be required to document a barrier to an in-person visit, nor shall the type of setting where
495 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
496 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
497 transmission of a patient’s medical information, such as digital images, documents, and pre-
498 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

499 SECTION 25. Chapter 176I of the General Laws, as appearing in the 2014 Official
500 Edition, is hereby amended by inserting at the end thereof the following new section:

501 Section 13: Notwithstanding any general or special law or rule or regulation to the
502 contrary, any contract between a covered person and an organization shall provide for coverage
503 for health care services to a subscriber through the use of telemedicine by a contracted health
504 care provider. . Such health care services shall be covered to the same extent as if they were
505 provided via in-person consultation or in-person delivery. Furthermore, such health care services
506 shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery
507 of the same contracted health care services.

508 A contract that provides coverage for telemedicine services may contain a provision for a
509 deductible, copayment or coinsurance requirement for a health care service provided through
510 telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,
511 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
512 services. For health care services provided through telemedicine, a health care provider shall not
513 be required to document a barrier to an in-person visit, nor shall the type of setting where

514 telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean
515 the use of two-way audio-visual interaction or store-and-forward technology, defined as the
516 transmission of a patient’s medical information, such as digital images, documents, and pre-
517 recorded video, from an originating site to the physician at the distant site for clinical evaluation.

518 SECTION 26. The General Laws are hereby amended by inserting after chapter 176O the
519 following chapter: A new Chapter 176O1/2 is hereby inserted.

520 Section 1. Definitions

521 As used in this chapter, the following words shall, unless the context clearly requires
522 otherwise, have the following meanings:-

523 “Clinician”, a physician licensed under section 2 of chapter 112, or advance practice
524 clinician, including but not limited to a physician assistant licensed pursuant to section 9F of
525 chapter 112, and advanced practice nurses, including but not limited to certified nurse
526 practitioners, certified registered nurse anesthetists, certified nurse midwives, and psychiatric
527 clinical nurse specialists licensed pursuant to section 80B of chapter 112.

528 “Clinician’s Allowed Amount”, a Clinician’s Usual and Customary Amount after the
529 discount applied under a Clinician’s contractual arrangement with an Insurance Carrier, if any, or
530 the amount of the allowed benefit if the Clinician is Out of Network. The Clinician’s Allowed
531 Amount constitutes the Clinician’s contractually adjusted total expected payment for a
532 professional service if the Clinician has a contractual arrangement with an Insurance Carrier.

533 “Clinicians’ Usual and Customary Charge”, the charges routinely billed by Clinicians’
534 for their professional services regardless of payer involved and before any discounts that are

535 applied pursuant to charity or indigent patient charge policies or Insurance Carrier contracting
536 discounts. Absent other considerations, the Usual and Customary Charge constitutes the
537 Clinician's total expected payment for a service.

538 "Emergency medical condition", a medical condition, whether physical, behavioral,
539 related to substance use disorder, or mental, manifesting itself by symptoms of sufficient
540 severity, including severe pain, that the absence of prompt medical attention could reasonably be
541 expected by a prudent layperson who possesses an average knowledge of health and medicine, to
542 result in placing the health of the insured or another person in serious jeopardy, serious
543 impairment to body function or serious dysfunction of any body organ or part or, with respect to
544 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.
545 S.C. section 1395dd(e)(1)(B).

546 "In Network Services", professional services provided to an Insured by Clinicians who
547 have contracted with the Insurance Carrier that insures the Insured.

548 "Insurance Carrier", an insurer licensed or otherwise authorized to transact accident or
549 health insurance under chapter 175; a nonprofit hospital service corporation organized under
550 chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health
551 maintenance organization organized under chapter 176G; and an organization entering into a
552 preferred provider arrangement under chapter 176I, but not including an employer purchasing
553 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or
554 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not
555 include any entity to the extent it offers a policy, certificate or contract that is not a health benefit
556 plan, as defined in section 1 of chapter 176J.

557 “Insurance Carrier Insured Allowable”, the benefit amount that the Carrier assigns for the
558 service rendered by a Clinician who has not entered into a contractual arrangement with the
559 Insurance Carrier that insures the Insured.

560 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
561 carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under
562 review, or any other individual whose care may be subject to review by a utilization review
563 program or entity as described under other provisions of chapter 176O.

564 “Insured Balance Bill”, the amount of the Clinician’s Usual and Customary Charge that
565 remains after the Insurance Carrier determines the Insurance Carrier Out of Network benefit and
566 Insured Cost Sharing amount.

567 “Insured Co-Insurance”, the portion of the Clinician’s charge for professional services
568 that the Insured is financially responsible for paying directly to the Clinician who rendered the
569 professional services pursuant to the terms of the contractual arrangement between the Insured
570 and the Insurance Carrier.

571 “Insured Co-Payment”, the amount that is the Insured’s responsibility for professional
572 services received from a Clinician, as dictated by the terms of the contractual arrangement
573 between the Insured and the Insurance Carrier. A co-pay amount may be stated as a percentage
574 or as a flat rate for services.

575 “Insured Cost Sharing”, the combination of the Insured Deductible, Co-Insurance and
576 Co-Payment or those amounts that are the responsibility of the Insured for a Clinician’s
577 professional services. Insured Cost Sharing for an Unavoidable Out of Network Services bill

578 shall be limited to the amount that the Insured would have paid the Clinician for In-Network
579 services.

580 “Insured Deductible”, the Insured’s financial responsibility for the Clinician’s charges
581 that is applied to the Clinician’s Usual and Customary charges before applying either co-
582 insurance or co-payments.

583 “Mediation”, the process to mediate disputes between an Insurance Carrier and Clinician
584 that is conducted outside of a formal court process; provided, however, that mediation shall only
585 be legally binding if the parties have mutually agreed to it in writing.

586 “Medicare Physician Fee Schedule”, the fee schedule modified and published annually by
587 the Centers for Medicare and Medicaid for professional services.

588 “Minimum Benefit Standard”, the greatest of the following amounts: (i) the amount the
589 insured's health care plan would pay for such services if rendered by an in-network health care
590 provider; (ii) the usual and customary rate for such services, or (iii) the amount Medicare would
591 reimburse for such services. As used in this subparagraph, "usual and customary rate" means the
592 eightieth percentile of all charges for the particular health care service performed by a health care
593 provider in the same or similar specialty and provided in the same geographical area, as reported
594 in an independent benchmarking database maintained by a nonprofit organization specified by
595 the Commissioner of the Division of Insurance. Such organization shall not be affiliated with any
596 health carrier.

597 “Opt Out Services”, Out of Network Clinician Services in an Inpatient Hospital or
598 Outpatient Hospital where the Insured voluntarily selects in writing to receive services from an
599 Out of Network Clinician and is offered an estimate of Out of Network Charges and consents in

600 writing to be treated by an Out of Network Clinician and be financially responsible for Out of
601 Network Services. Opt Out Services shall not include emergency department services and any
602 related on call services provided to an Insured whose care begins in an emergency department.

603 "Out of Network Services", a Clinician's professional services provided to an Insured
604 where the Clinician is not contracted with both the Insured's Insurance Carrier and the Insured's
605 health insurance product/plan offered by the Insured's Insurance Carrier.

606 "Self-Funded Health Benefits Plan" or "Self-Funded Plan", a self-insured health benefits
607 plan governed by the provisions of the federal "Employee Retirement Income Security Act of
608 1974," 29 U.S.C. s.1001 et seq.

609 "Unavoidable Out of Network bill", a bill for Out of Network Services received by an
610 insured for services rendered by a Clinician, where such Out of Network Services were rendered
611 by such out-of-network Clinician at an in-network facility, or during a service or procedure
612 previously approved or authorized by the health carrier and the insured did not have the ability to
613 control to select such services from an in-network Clinician. A bill for Out of Network Services
614 received by an Insured to screen for, evaluate, diagnose and/or treat an emergency medical
615 condition by an out-of-network Clinician at an in-network facility shall be deemed an
616 "Unavoidable Out of Network bill". "Unavoidable Out of Network bill" does not include a bill
617 for non-emergency services received by an insured when the insured voluntarily selects in
618 writing an out of network Clinician prior to the provision of the service or when the insured has
619 the ability and control to select an in-network Clinician prior to the provision of the service but
620 declines to exercise that option.

621 Section 2. The Minimum Benefit Standard for Insured Services

622 (a) If Out of Network Services are provided to an Insured by a Clinician resulting in
623 an Unavoidable Out of Network bill, such Clinician shall bill the Insured's Insurance Carrier
624 directly and the Insurance Carrier shall pay the Clinician for the professional services as coded
625 and billed by the Clinician;

626 (b) Insurance Carriers shall make payment directly to the Clinician for an
627 Unavoidable Out of Network bill for covered services within 30 calendar days of the submission
628 of claim by the Clinician;

629 (c) The Insurance Carrier shall adjudicate the Insured's claim for Out of Network
630 Services that result in an Unavoidable Out of Network bill at the Insured's In-Network benefits
631 levels and the Insured's Cost Sharing for Out of Network Services shall be limited to amount that
632 the Insured would have paid the Clinician for In-Network services;

633 (d) Insured Deductible for Out of Network services that result in an Unavoidable Out
634 of Network bill shall be applied by the Insurance Carrier to Insured's Deductible for in-network
635 services;

636 (e) Insurance Carriers shall make payment directly to the clinician providing Out of
637 Network Services that result in an Unavoidable Out of Network bill at an amount not less than
638 the Minimum Benefit Standard.

639 (f) Clinicians shall be prohibited from submitting a claim or charges for an Insured
640 Balance Bill for Unavoidable Out of Network services to the Insured, provided that the
641 Minimum Benefit Standard has been paid to the Clinician by the Insurance Carrier and provided
642 that the Insured has not Opted Out of these protections for non-emergency services pursuant to
643 section 3 of this chapter;

644 (g) In the case of services provided to a member of a Self-Funded Plan that does not
645 elect to be subject to the provisions of this section, the Clinician shall be permitted to bill the
646 covered person in excess of the applicable deductible, copayment, or coinsurance amounts.

647 Section 3. Opt Out Services

648 (a) A Clinician shall be prohibited from Insured Balance Billing for Unavoidable Out
649 of Network services, except in the case of Opt Out Services.

650 (b) If there is a dispute regarding the Involuntary Out of Network service payment or
651 charges the Clinician may institute mediation pursuant to the provisions of this chapter.

652 Section 4. Mediation

653 (a) A Clinician may initiate the mediation process by providing written notice of the
654 dispute to the Insurance Carrier and the entity that will determine the mediation process.

655 (b) Mediation resolution shall be within 30 days of the date the mediation request is
656 received by the Insurance Carrier, and Division of Insurance or its designee shall determine the
657 mediation process.

658 (c) A Clinician shall be permitted to bundle similar claims or claims presenting
659 common issues of fact or law can be bundled together and adjudicated in one mediation process
660 to promote speedy dispute resolutions.

661 (d) The mediation official may select from either party's proposal but shall not create
662 his own reimbursement rate.

663 (e) The Medicare Physician Fee Schedule shall not be used as a reference point for
664 mediation process as it is a statutory and regulated fee schedule subject to budgetary and policy
665 limitations established by Congress and Center for Medicare and Medicaid Services.

666 Section 5. False or Misleading Statements in Insurance Carrier Information

667 An Insurance Carrier shall not state, communicate or include in written form false,
668 misleading or confusing information in their explanation of benefits to Insureds regarding
669 Clinician Usual and Customary Charges, Out of Network Balance Billing, or mediation disputes
670 between Clinicians and Insurance Carriers.

671 Section 6. Enforcement for non-compliance by Insurance Carriers or Clinicians

672 (a) A Clinician shall be prohibited from submitting a claim or charges in violation of
673 this chapter.

674 (b) A Clinician who engages in a pattern and practice of regularly sending or
675 communicating Out of Network Balance Bills to an Insured in violation of these provisions,
676 except for cases of excusable neglect, shall lose the right to file mediation demands under
677 provisions of this chapter.

678 (c) An Insurance Carrier that is in violation of this chapter is subject to sanctions,
679 penalties and other corrective actions by the Division of Insurance

680 Section 7. Disclosure

681 (a) An Insurance Carrier shall inform an Insured or the Insured's Clinician, as
682 applicable, at the time the Insured or the Insured's Clinician requests a prospective or concurrent
683 review: (1) the network status under the Insured's health benefit plan of the Clinician who will

684 be providing the health care service or course of treatment; and (2) an estimate of the amount the
685 Insurance Carrier will pay such Clinician for such service or treatment pursuant to the Minimum
686 Benefit Standard.

687 (b) At the time of scheduling an admission, procedure or service for an insured
688 patient or prospective patient, a health care provider shall: (i) determine the provider's own
689 network status relative to insured's insurance carrier and specific health benefit plan and disclose
690 in real time such network status to the insured.

691 (c) At the time of scheduling an admission, procedure or service for an insured
692 patient or prospective patient, a health care provider, upon request by a patient or prospective
693 patient, shall (i) notify the patient or prospective patient of their right to request and obtain from
694 the provider provide, based on information available to the provider at the time of the request,
695 additional information on the network status of any provider reasonably expected to render
696 services in the course of such admission, procedure or service that is necessary for the patient's
697 or prospective patient's use of a health benefit plan's toll-free number and website available
698 pursuant to section 23 of chapter 176O to obtain additional information about that provider's
699 network status under the patient's or prospective patient's health benefit plan and any applicable
700 out-of-pocket costs for services sought from such provider; (ii) provide, based on information
701 available to the provider at the time of the request, information on such admission, procedure or
702 service that is necessary for the patient's or prospective patient's use of a health benefit plan's
703 toll-free number and website available pursuant to section 23 of chapter 176O to identify the
704 allowed amount or charge of the admission, procedure or service, including the amount for any
705 facility fees required; (iii) notify the patient or prospective patient that in the event a health care
706 provider is unable to quote a specific allowed amount or charge in advance of the admission,

707 procedure or service due to the health care provider's inability to predict the specific treatment or
708 diagnostic code, the estimated maximum allowed amount or charge for a proposed admission,
709 procedure or service, including the amount for any facility fees required; and (iv) inform the
710 patient or prospective patient that the estimated costs and the actual amount the patient or
711 prospective patient may be responsible to pay may vary due to unforeseen services that arise out
712 of the proposed admission, procedure or service. This subsection shall not apply in cases of
713 emergency services provided to a patient.

714 (d) If a network provider schedules, orders or otherwise arranges for services related
715 to an insured's admission, procedure or service and such services are performed by another
716 health care provider, or if a network provider refers an insured to another health care provider for
717 an admission, procedure or service, then in addition to the actions required pursuant to
718 subsection

719 (b) the network provider shall, based on information available to the provider at that time:
720 (i) disclose to the insured if the provider to whom the patient is being referred is part of or
721 represented by the same provider organization registered pursuant to section 11 of chapter 6D;

722 (ii) disclose verbally or in writing to the insured sufficient information about such
723 provider for the patient to obtain information about that provider's network status under the
724 insured's health benefit plan and identify any applicable out-of-pocket costs for services sought
725 from such provider through the toll-free number and website of the insurance carrier available
726 pursuant to section 23 of chapter O; and (iii) notify verbally or in writing the insured that if the
727 health care provider is out-of-network under the patient's health insurance policy, that the
728 admission, service or procedure will likely be deemed out-of-network and that any out-of-

729 network applicable rates under such policy may apply. This subsection shall not apply in cases of
730 emergency services provided to a patient.

731 Section 8. Self-Funded Plans

732 (a) With respect to an entity providing or administering a Self-Funded Health
733 Benefits Plan and its plan members, this Chapter shall only apply if the plan elects to be subject
734 to the provisions of this Chapter. To elect to be subject to the provisions of this Chapter, the
735 self-funded plan shall provide notice, on an annual basis, to the Division of Insurance, on a form
736 and in a manner prescribed by the Division, attesting to the plan's participation and agreeing to
737 be bound by the provisions of this Chapter. The self-funded plan shall amend the employee
738 benefit plan, coverage policies, contracts and any other plan documents to reflect that the
739 benefits of this section shall apply to the plan's members.

740 (b) An Insurance Carrier, and any other entity providing or administering a Self-
741 Funded Health Benefits Plan that elects to be subject to this Chapter, shall issue a health
742 insurance identification card to the primary insured under a health benefits plan. In a form and
743 manner to be prescribed by the department, the card shall indicate whether the plan is insured or,
744 in the case of self-funded plans that elect to be subject to this Chapter, whether the plan is self-
745 funded and whether the plan elected to be subject to this act.

746 SECTION 27. The provisions of SECTIONS 13, 14, 20 – 25 shall be effective for all
747 contracts which are entered into, renewed, or amended one year after the effective date of this
748 Act