

**HOUSE . . . . . No. 967**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***Tricia Farley-Bouvier***

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to protect consumers from surprise medical bills.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Tricia Farley-Bouvier</i>	<i>3rd Berkshire</i>	<i>1/17/2019</i>
<i>Brian M. Ashe</i>	<i>2nd Hampden</i>	<i>2/1/2019</i>
<i>Christine P. Barber</i>	<i>34th Middlesex</i>	<i>1/25/2019</i>
<i>Natalie M. Blais</i>	<i>1st Franklin</i>	<i>1/31/2019</i>
<i>Michael D. Brady</i>	<i>Second Plymouth and Bristol</i>	<i>1/31/2019</i>
<i>Michelle L. Ciccolo</i>	<i>15th Middlesex</i>	<i>2/1/2019</i>
<i>Mike Connolly</i>	<i>26th Middlesex</i>	<i>1/25/2019</i>
<i>Marjorie C. Decker</i>	<i>25th Middlesex</i>	<i>1/31/2019</i>
<i>Sal N. DiDomenico</i>	<i>Middlesex and Suffolk</i>	<i>1/30/2019</i>
<i>Mindy Domb</i>	<i>3rd Hampshire</i>	<i>1/30/2019</i>
<i>Carolyn C. Dykema</i>	<i>8th Middlesex</i>	<i>1/25/2019</i>
<i>James B. Eldridge</i>	<i>Middlesex and Worcester</i>	<i>1/29/2019</i>
<i>Carmine Lawrence Gentile</i>	<i>13th Middlesex</i>	<i>1/30/2019</i>
<i>Carlos González</i>	<i>10th Hampden</i>	<i>2/1/2019</i>
<i>Tami L. Gouveia</i>	<i>14th Middlesex</i>	<i>2/1/2019</i>
<i>James K. Hawkins</i>	<i>2nd Bristol</i>	<i>1/29/2019</i>
<i>Stephan Hay</i>	<i>3rd Worcester</i>	<i>1/22/2019</i>
<i>Jonathan Hecht</i>	<i>29th Middlesex</i>	<i>1/31/2019</i>

<i>Natalie M. Higgins</i>	<i>4th Worcester</i>	<i>1/29/2019</i>
<i>Steven S. Howitt</i>	<i>4th Bristol</i>	<i>1/30/2019</i>
<i>Daniel J. Hunt</i>	<i>13th Suffolk</i>	<i>1/30/2019</i>
<i>Randy Hunt</i>	<i>5th Barnstable</i>	<i>1/28/2019</i>
<i>Kay Khan</i>	<i>11th Middlesex</i>	<i>1/30/2019</i>
<i>Jack Patrick Lewis</i>	<i>7th Middlesex</i>	<i>2/1/2019</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>	<i>1/24/2019</i>
<i>Elizabeth A. Malia</i>	<i>11th Suffolk</i>	<i>2/1/2019</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>	<i>1/29/2019</i>
<i>David M. Rogers</i>	<i>24th Middlesex</i>	<i>1/28/2019</i>
<i>Alan Silvia</i>	<i>7th Bristol</i>	<i>2/1/2019</i>
<i>José F. Tosado</i>	<i>9th Hampden</i>	<i>1/31/2019</i>
<i>Steven Ultrino</i>	<i>33rd Middlesex</i>	<i>1/30/2019</i>

**HOUSE . . . . . No. 967**

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By Ms. Farley-Bouvier of Pittsfield, a petition (accompanied by bill, House, No. 967) of Tricia Farley-Bouvier and others for legislation to require specific patient consent for out-of-network healthcare services and prohibiting providers from billing consumers for more than the in-network cost-sharing amount. Financial Services.

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**The Commonwealth of Massachusetts**

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

An Act to protect consumers from surprise medical bills.

*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. Said chapter 6D is hereby further amended by inserting after section 16 the  
2 following section:-

3           Section 16A. (a) The commission shall, upon consideration of advice or any other  
4 pertinent evidence, recommend the noncontracted commercial rate for emergency services and  
5 the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter  
6 176O. The noncontracted commercial rate for emergency services and the noncontracted  
7 commercial rate for nonemergency services shall be in effect for a term of 5 years and shall  
8 apply to payments under clauses (ii) and (iv) of section 28 of said chapter 176O.

9           (b) In recommending rates, the commission shall consider: (i) the impact of each rate on  
10 the growth of total health care expenditures; (ii) the impact of each rate on in-network  
11 participation by health care providers; and (iii) whether each rate is easily understandable and

12 administrable by health care providers and carriers. The commission shall not issue its  
13 recommendations for the noncontracted commercial rate for emergency services and the  
14 noncontracted commercial rate for nonemergency services without the approval of the board  
15 established under subsection (b) of section 2.

16 (c) If the board approves the recommendations pursuant to subsection (b), the  
17 commission shall submit the recommendations to the division of insurance. The division may,  
18 not later than 30 days after the proposal has been submitted, hold a public hearing on the  
19 proposal. The division shall issue any findings within 20 days after the public hearing and shall  
20 make public those findings and any proposed regulation to implement those findings with respect  
21 to the recommendations of the commission. If the division does not issue final regulations with  
22 respect to the recommendations within 65 days after the commission submits the  
23 recommendations to division, the recommendations shall be adopted by the division as the  
24 noncontracted commercial rate for emergency services and noncontracted commercial rate for  
25 nonemergency services in effect for the applicable 5-year term.

26 (d) Prior to recommending the rates, the commission shall hold a public hearing. The  
27 hearing shall examine current rates paid for in- and out-of-network services and the impact of  
28 those rates on the operation of the health care delivery system and determine, based on the  
29 testimony, information and data, an appropriate noncontracted commercial rate for emergency  
30 services and noncontracted commercial rate for nonemergency services consistent with  
31 subsection (b). The commission shall provide public notice of the hearing not less than 45 days  
32 before the date of the hearing, including notice to the division of insurance. The division may  
33 participate in the hearing. The commission shall identify as witnesses for the public hearing a

34 representative sample of providers, provider organizations, payers and other interested parties as  
35 the commission may determine. Any interested party may testify at the hearing.

36 (e) The commission shall conduct a review of established rates in the fourth year of the  
37 rates' operation. The commission shall further hold a public hearing under subsection (d) in said  
38 fourth year and recommend rates consistent with this section to be effective for the next 5-year  
39 term.

40 SECTION 2. Said chapter 111 is hereby further amended by striking out section 228, as  
41 so appearing, and inserting in place thereof the following 2 sections:

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

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

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

47 "Emergency medical condition", as defined in section 1 of chapter 6D.

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

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

53 "Hospital", as de fined in section 1 of chapter 6D.

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

55 “Insured”, as defined in section 1 of chapter 176O.

56 “Network provider”, as defined in section 1 of chapter 176O

57 “Network status”, as defined in section 1 of chapter 176O.

58 “Out-of-network provider”, as defined in section 1 of chapter 176O.

59 “Prior written consent”, a signed written consent form provided to a patient or  
60 prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-  
61 network provider rendering health care services, other than for emergency services, when said  
62 services are scheduled at least 24 hours in advance of the rendering of care, to such patient or  
63 prospective patient or, if that person lacks capacity to consent, signed by the person authorized to  
64 consent for such a patient or prospective patient. A prior written consent form shall be presented  
65 in a manner and format to be determined by the commissioner of public health in consultation  
66 with the division of insurance; provided, that such consent form shall be a document that is  
67 separate from any other document used to obtain the consent of the patient or prospective patient  
68 for any other part of the care or procedure; and provided further, that such consent form shall  
69 include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-  
70 network status to the patient or prospective patient; (ii) a statement affirming that the out-of-  
71 network provider informed the patient or prospective patient that services rendered by an out-of-  
72 network provider may result in costs not covered by the patient's or prospective patient's carrier  
73 or specific health benefit plan; (iii) a statement affirming that the out-of-network provider  
74 informed the patient or prospective patient that services may be available from a contracted  
75 provider and that the patient or prospective patient is not required to obtain care from the out-of-

76 network provider; (iv) a statement affirming that the out-of-network provider presented the  
77 patient or prospective patient with a written estimate of the patient or prospective patient's total  
78 out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative  
79 declaration of the patient's or prospective patient's consent to receive health care services from  
80 the out-of-network provider, signed by the patient or prospective patient, or by the person  
81 authorized to consent for such a patient or prospective patient.

82 (b) At the time of scheduling an admission, procedure or service for an insured patient or  
83 prospective patient, a health care provider shall: (i) determine the provider's own network status  
84 relative to insured's insurance carrier and specific health benefit plan and disclose in real time  
85 such network status to the insured; (ii) notify the patient or prospective patient of their right to  
86 request and obtain from the provider, based on information available to the provider at the time  
87 of the request, additional information on the network status of any provider reasonably expected  
88 to render services in the course of such admission, procedure or service that is necessary for the  
89 patient's or prospective patient's use of a health benefit plan's toll-free number and website  
90 available pursuant to

91 section 23 of chapter 176O to obtain additional information about that provider's network  
92 status under the patient's or prospective patient's health benefit plan and any applicable out-of-  
93 pocket costs for services sought from such provider; (iii) notify the patient or prospective patient  
94 of their right to request and obtain from the provider, based on information available to the  
95 provider at the time of the request, information on such admission, procedure or service that is  
96 necessary for the patient's or prospective patient's use of a health benefit plan's toll-free number  
97 and website available pursuant to section 23 of chapter 176O to identify the allowed amount or  
98 charge of the admission, procedure or service, including the amount for any facility fees

99 required; (iv) notify the patient or prospective patient that in the event a health care provider is  
100 unable to quote a specific allowed amount or charge in advance of the admission, procedure or  
101 service due to the health care provider's

102 inability to predict the specific treatment or diagnostic code, the health care provider shall  
103 disclose to the patient or prospective patient the estimated maximum allowed amount or charge  
104 for a proposed admission, procedure or service, including the amount for any facility fees  
105 required; and (iv) inform the patient or prospective patient that the estimated costs and the actual  
106 amount the patient or prospective patient may be responsible to pay may vary due to unforeseen  
107 services that arise out of the proposed admission, procedure or service. This subsection shall not  
108 apply in cases of services provided to a patient to treat an emergency medical condition.

109 (c) If a network provider schedules, orders or otherwise arranges for services related to an  
110 insured's admission, procedure or service and such services are performed by another health care  
111 provider, or if a network provider refers an insured to another health care provider for an  
112 admission, procedure or service, then in addition to the actions required pursuant to subsection  
113 (b) the network provider shall, based on information available to the provider at that time: (i)  
114 disclose to the insured if the provider to whom the patient is being referred is part of or  
115 represented by the same provider organization registered pursuant to section 11 of chapter 6D;  
116 (ii) disclose to the insured sufficient information about such provider for the patient to obtain  
117 information about that provider's network status under the insured's health benefit plan and  
118 identify any applicable out-of-pocket costs for services sought from such provider through the  
119 toll-free number and website of the insurance carrier available pursuant to section 23 of chapter  
120 176O; and (iii) notify the insured that if the health care provider is out-of-network under the  
121 patient's health insurance policy, that the admission, service or procedure will likely be deemed



122 out-of-network and that any out-of-network applicable rates under such policy may apply. This  
123 subsection shall not apply in cases of services provided to a patient to treat an emergency  
124 medical condition.

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

139 SECTION 3. Section 1 of chapter 176O of the General Laws, as appearing in the 2016  
140 Official Edition, is hereby amended by inserting after the definition of "Incentive plan" the  
141 following definition:-

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

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

149            SECTION 4. Said section 1 of said chapter 176O, as so appearing, is hereby further  
150 amended by inserting after the definition of “Network” the following 5 definitions:

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

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

156            “Noncontracted commercial rate for emergency services, the amount set pursuant to  
157 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for  
158 the provision of emergency health care services to an insured when the health care provider is  
159 not in the carrier’s network.

160            “Noncontracted commercial rate for nonemergency services, the amount set pursuant to  
161 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for

162 the provision of nonemergency health care services to an insured when the health care provider  
163 is not in the carrier's network.

164 "Nonemergency services, health care services rendered to an insured experiencing a  
165 condition other than an emergency medical condition.

166 SECTION 5. Said section 1 of said chapter 176O, as so appearing, is hereby further  
167 amended by inserting after the definition of "Office of patient protection" the following  
168 definition:-

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

175 SECTION 6. Said section 1 of said chapter 176O, as so appearing, is hereby further  
176 amended by inserting after the definition of "Second opinion" the following definition:

177 "Surprise bill", a bill for health care services, other than for emergency services, received  
178 by an insured for the services of an out-of-network provider rendered at or by a network facility  
179 in the insured's health benefit plan or as result of a referral from an in-network provider to an  
180 out-of-network provider where: (i) a network provider is unavailable; (ii) the out-of-network  
181 provider renders services without the insured's knowledge; (iii) services were referred by a  
182 network provider to an out-of-network provider without the prior written consent of the insured  
183 acknowledging the out-of-network referral or services and that such services rendered may result

184 in costs not covered by the health benefit plan; or (iv) unforeseen medical services that require  
185 the services that are necessary to be performed by an out-of-network provider arise at the time  
186 the health care services are rendered; provided however, that “surprise bill” shall not mean a bill  
187 received for health care services rendered when a network provider is available and the insured  
188 affirmatively elected to receive services from an out-of-network provider.

189 SECTION 7. Section 6 of said chapter 176O, as so appearing, is hereby amended by  
190 striking out, in lines 33 and 34, the words “has a reasonable opportunity to choose to have the  
191 service performed by a network provider” and inserting in place thereof the following words: -

192 affirmatively chooses to receive services from an out-of-network provider pursuant to  
193 section 28 and the out-of-network provider has obtained the prior written consent of the insured  
194 pursuant to section 228 of chapter 111.

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

198 (8)(i) a clear description of the procedure, if any, by which the insured may request an  
199 out-of-network referral; (ii) a summary description of the methodology used by the insurer to  
200 determine reimbursement of out-of-network health care services; (iii) the amount that the insurer  
201 will reimburse under the methodology for out-of-network services pursuant to sections 28; and  
202 (iv) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care  
203 services;

204 SECTION 9. Said chapter 176O is hereby further amended by striking out section 23, as  
205 so appearing, and inserting in place thereof the following section:

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

216 The telephone number and website shall inform the insured that the insured shall not be  
217 required to pay more than the estimated amounts disclosed in the written notice for the covered  
218 health care benefits that were actually provided; provided however, that nothing in this section  
219 shall prevent carriers from imposing cost sharing requirements disclosed in the insured's  
220 evidence of coverage document provided by the carrier for unforeseen services that arise out of  
221 the proposed admission, procedure or service; and provided further, that the carrier shall alert the  
222 insured that these are estimated costs, and that the actual amount the insured will be responsible  
223 to pay may vary due to unforeseen services that arise out of the proposed admission, procedure  
224 or service, except that the insured shall not be responsible for any additional payment caused by  
225 the carrier mistakenly identifying an out-of-network provider as in-network.

226 The information provided on the website shall conform to the uniform methodology for  
227 the communication of information about the assignment of tiers to health care providers and

228 health care services adopted by the center for health information and analysis pursuant to section  
229 24 of chapter 12C.

230 SECTION 10. Said chapter 176O is hereby further amended by adding the following  
231 section:

232 Section 28. (a)(1) A carrier shall reimburse a health care provider as follows: (i) where  
233 the health care provider is a member of an insured's carrier's network but not a participating  
234 provider in the insured's health benefit plan and the health care provider has delivered health  
235 care services to the insured to treat an emergency medical condition, the carrier shall pay that  
236 provider the in-network contracted rate for each delivered service; provided, however, that such  
237 payment shall constitute payment in full to that health care provider and the provider shall not  
238 bill the insured except for any applicable copayment, coinsurance or deductible that would be  
239 owed if the insured received such service or services from a participating health care provider  
240 under the terms of the insured's health benefit plan;

241 (ii) where the health care provider is not a member of an insured's carrier's network and  
242 the health care provider has delivered health care services to the insured to treat an emergency  
243 medical condition, the carrier shall pay that provider the noncontracted commercial rate for  
244 emergency services for each delivered service; provided, however, that such payment shall  
245 constitute payment in full to the health care provider and the provider shall not bill the insured  
246 except for any applicable copayment, coinsurance or deductible that would be owed if the  
247 insured received such service or services from a participating health care provider under the  
248 terms of the insured's health benefit plan;

249 (iii) where the health care provider is a member of an insured's carrier's network but not  
250 a participating provider in the insured's health benefit plan and the health care provider has  
251 delivered nonemergency health care services to the insured and a participating provider in the  
252 insured's health benefit plan is unavailable or the health care provider renders those  
253 nonemergency health care services without the insured's knowledge, the carrier shall pay that  
254 provider the in-network contracted rate for each delivered service; provided, however, that such  
255 payment shall constitute payment in full to the health care provider and the provider shall not bill  
256 the insured except for any applicable copayment, coinsurance or deductible that would be owed  
257 if the insured received such service from a participating health care provider under the terms of  
258 the insured's health benefit plan; and

259 (iv) where the health care provider is not a member of an insured's carrier's network and  
260 the health care provider has delivered nonemergency services to the insured and a participating  
261 provider in the insured's health benefit plan is unavailable or the health care provider renders  
262 those nonemergency health care services without the insured's knowledge, the carrier shall pay  
263 the provider the noncontracted commercial rate for nonemergency services for each delivered  
264 service; provided, however, that such payment shall constitute payment in full to the health care  
265 provider and the provider shall not bill the insured except for any applicable copayment,  
266 coinsurance or deductible that would be owed if the insured received such service or services  
267 from a participating health care provider under the terms of the insured's health benefit plan.

268 (2) An insured shall not be liable for the payment of surprise bills, shall pay no more than  
269 the in-network cost-sharing amount and shall not owe an out-of-network provider more than the  
270 in-network cost-sharing amount for services subject to this section.

271 (3) It shall be an unfair and deceptive act or practice, in violation of section 2 of chapter  
272 93A, for any health care provider or carrier to request payment from an enrollee, other than the  
273 applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services  
274 described in paragraph (1).

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

277 (c) Nothing in this section shall require a carrier to pay for nonemergency health care  
278 services delivered to an insured by an out-of-network provider that has obtained prior written  
279 consent of the insured pursuant to section 228 of chapter 111.

280 (d) The commissioner shall promulgate regulations that are necessary to implement this  
281 section.

282 SECTION 11. Notwithstanding any general or special law to the contrary, the  
283 noncontracted commercial rate for nonemergency services under chapter 176O of the General  
284 Laws shall be not more than the eightieth percentile of all allowed charges for a particular health  
285 care service performed by a health care provider in the same or similar specialty and provided in  
286 the same geographical area, as reported in a benchmarking database by a nonprofit organization  
287 specified by the division of insurance. Such an organization shall not be affiliated with a health  
288 carrier.

289 SECTION 12. Notwithstanding any general or special law to the contrary, the  
290 noncontracted commercial rate for emergency services under chapter 176O of the General Laws  
291 shall be not more than the eightieth percentile of all allowed charges for a particular health care  
292 service performed by a health care provider in the same or similar specialty and provided in the



293 same geographical area, as reported in a benchmarking database by a nonprofit organization  
294 specified by the division of insurance. Such an organization shall not be affiliated with any  
295 health carrier.

296 SECTION 13. Sections 11 and 12 are hereby repealed.

297 SECTION 14. Section 13 shall take effect on December 31, 2020.