HOUSE DOCKET, NO. 1762 FILED ON: 1/17/2019

HOUSE . . . . . No. 967

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

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

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HOUSE . . . . . No. 967

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.

The Commonwealth of Massachusetts

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:

SECTION 1. Said chapter 6D is hereby further amended by inserting after section 16 the following section:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 13. Sections 11 and 12 are hereby repealed.

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