HOUSE DOCKET, NO. 1790 FILED ON: 1/17/2019

HOUSE . . . . . No. 957

The Commonwealth of Massachusetts

PRESENTED BY:

Paul J. Donato

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 billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Paul J. Donato	*35th Middlesex*	*1/16/2019*
Carmine Lawrence Gentile	*13th Middlesex*	*1/22/2019*
Sean Garballey	*23rd Middlesex*	*1/25/2019*

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HOUSE . . . . . No. 957

By Mr. Donato of Medford, a petition (accompanied by bill, House, No. 957) of Paul J. Donato, Carmine Lawrence Gentile and Sean Garballey relative to non-contracted and non-emergency healthcare billing. Financial Services.

The Commonwealth of Massachusetts

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

An Act to protect consumers from surprise billing.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 6D of the General Laws, as appearing in the 2016 Official Edition, is hereby 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 premiums under Chapter 176J; (iii) the impact of each rate on in-network participation by health care providers and the risk of reducing network participation by health care providers; and (iv) whether each

rate is easily understandable and administrable by health care providers and carriers. The commission may establish separate rates for subsidized and nonsubsidized health benefit plans. 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. Chapter 32A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following 3 sections:-

Section 28. (a) As used in this section, "facility fee", "health system", "hospital" and "hospital-based facility" shall have the same meanings as provided in section 28 of chapter 176O.

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not impose a separate copayment on an insured or provide reimbursement to a hospital, health system or hospital-based facility for services provided at a hospital, a health system or a hospital-based facility or for reimbursement to such a hospital, health system or hospital-based facility for a facility fee for services utilizing a current procedural terminology evaluation and management code or which is otherwise limited pursuant to section 51L of chapter 111.

A hospital, health system or hospital-based facility shall not charge, bill or collect from an insured a facility fee greater than the facility fee reimbursement rate agreed to by the carrier pursuant to an insured's policy.

(c) Nothing in this section shall prohibit the commission from offering coverage that restricts the reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

SECTION 3. Chapter 111 of the General Laws, as appearing in the 2016 Official Edition, is hereby r amended by inserting after section 51K the following section:-

Section 51L. (a) For the purposes of this section, the following terms shall have the following meanings unless the context clearly indicates otherwise:

"Campus", the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located not more than 250 yards from the main buildings or other area that has been determined on an individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's campus.

"Carrier", shall have the same meaning as provided in section 1 of chapter 176O.

"Facility fee", shall have the same meaning as provided in section 28 of chapter 176O.

"Health system", shall have the same meaning as provided in section 28 of chapter 176O.

"Hospital-based facility", shall have the same meaning as provided in section 28 of chapter 176O.

(b) A hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee for services utilizing a current procedural terminology evaluation and management code or other current procedural terminology code as determined by the department. A hospital, health system or hospital-based facility shall not offset the loss of revenue from facility fees

through increased rates, fees or charges on carriers or an insured. A violation of this subsection shall be an unfair trade practice under chapter 93A.