

# SENATE . . . . . No. 2364

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## The Commonwealth of Massachusetts

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In the One Hundred and Ninety-First General Court  
(2019-2020)  
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Senate, October 7, 2019

The committee on Financial Services, to whom was referred the petition (accompanied by bill, Senate, No. 659) of James T. Welch, José F. Tosado and James K. Hawkins for legislation to protect access to invaluable, economical, and necessary treatments,- reports the accompanying bill (Senate, No. 2364).

For the committee,  
James T. Welch

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## The Commonwealth of Massachusetts

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In the One Hundred and Ninety-First General Court  
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An Act to protect access to invaluable, economical and necessary treatments.

*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. Chapter 6D of the General Laws, as appearing in the 2016 Official Edition,  
2 is hereby amended by adding the following subsection:-

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 30 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.

(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 section:-

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, health system or hospital-based facility or for reimbursement to any such 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, as appearing in the 2016 Official Edition, is hereby 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 any 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 if the service was provided by a hospital-based facility located off of a campus unless the facility fee was charged, billed or collected by the hospital-based facility on or before July 1, 2017. A violation of this subsection shall be an unfair trade practice under chapter 93A.

(c) The department may identify additional conditions or factors that would prohibit a hospital, health system or hospital-based facility from charging, billing or collecting a facility fee

for health care services. Additional conditions or factors may include, but shall not be limited to:

- (i) additional current procedural terminology codes for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee;
- (ii) health care services for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee;
- (iii) limitations on physical locations, including whether on a campus or not, for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and
- (iv) other conditions or factors.

The department shall forward any recommendations under this subsection to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 4. Chapter 111, as appearing in the 2016 Official Edition, is hereby amended by striking out section 228, and inserting in place thereof the following section:-

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

“Allowed amount” shall mean 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 176O.

“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

99 intended to compensate the health care provider, health care provider group or a hospital for the  
100 operational expenses and is separate and distinct from a professional fee.

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

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

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

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

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

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

117 “Prior written consent”, a signed written consent form provided to a patient or  
118 prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-  
119 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 (v) 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 participate 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 5. 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.

SECTION 6. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following 3 definitions:-

“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 as defined in section 1 of chapter 176O.

SECTION 7. 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 8. Subsection (a) of section 6 of said chapter 176O, as appearing in the 2016 Official Edition, is hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; and (ii) an

232 explanation that whenever a location is part of the carrier's network, that the carrier shall cover  
233 medically necessary covered benefits delivered at that location and the insured shall not be  
234 responsible to pay more than the amount required for network services even if part of the  
235 medically necessary covered benefits are performed by out-of-network providers unless the  
236 insured affirmatively chooses to receive services from an out-of-network provider and the out-of-  
237 network provider has obtained the prior written consent of the insured pursuant to section 228 of  
238 chapter 111.

239 SECTION 9. Subsection (a) of said section 6 of said chapter 176O, as so appearing, is  
240 hereby further amended by striking out clause (8) and inserting in place thereof the following  
241 clause:-

242 (8)(i) a clear description of the procedure, if any, by which the insured may request an  
243 out-of-network referral; (ii) a summary description of the methodology used by the insurer to  
244 determine reimbursement of out-of-network health care services; (iii) the amount that the insurer  
245 will reimburse under the methodology pursuant to sections 29 and 30; and (iv) examples of  
246 anticipated out-of-pocket costs for frequently billed out-of-network health care services;

247 SECTION 10. Section 23 of said chapter 176O, as appearing in the 2016 Official  
248 Edition, is hereby amended by striking out section 23, , and inserting in place thereof the  
249 following section:-

250 Section 23. All carriers shall establish a toll-free telephone number and website that  
251 enables consumers to request and obtain from the carrier, in real time, the network status of an  
252 identified health care provider and the estimated or maximum allowed amount or charge for a  
253 proposed admission, procedure or service, and the estimated amount the insured will be

254 responsible to pay for a proposed admission, procedure or service that is a medically necessary  
255 covered benefit, based on the information available to the carrier at the time the request is made,  
256 including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for  
257 any covered health care benefits. All carriers shall create a mechanism by which the insured can  
258 request notice of the estimated amount in writing. Upon request, the carrier shall send the  
259 consumer written notice of the estimated amount the insured will be responsible for paying.

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

270         SECTION 11. Chapter 176O, as appearing in the 2016 Official Edition, is hereby further  
271 amended by adding the following 5 sections:-

272         Section 28. (a) As used in this section, the following words shall have the following  
273 meanings unless the context clearly requires otherwise:

274         “Facility fee”, a fee charged or billed by a hospital or health system for outpatient  
275 hospital services provided in a hospital-based facility that is intended to compensate the hospital

or health system for the operational expenses of the hospital or health system and is separate and distinct from a professional fee.

“Health system”, shall have the same meaning as “Provider Organization or Health System or System”, as provided by the health policy commission.

“Hospital”, a hospital licensed pursuant to section 51 of chapter 111.

“Hospital-based facility”, a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided.

“Professional fee”, a fee charged or billed by a provider, hospital or health system for professional medical services provided in a hospital-based facility.

(b) If a hospital or health system charges a facility fee for services that are not subject to the limitations of section 51L of chapter 111, the hospital or health system shall provide any patient receiving such a service with written notice of the fee. The notice shall the following: (i) a statement of disclosure informing the patient that the hospital, hospital-based facility, or provider has charged or billed a facility fee that is in addition to and separate from the professional fee charged by the provider; (ii) the amount of the facility fee charged or billed, or, if the exact type and extent of the facility fee is not known with reasonable certainty, an estimate of the facility fee; (iii) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient; (iv) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and (v) that a patient covered by a health insurance policy should contact the health insurer to receive information about

alternative providers that do not charge a facility fee, a statement that the patient may be billed separately for that facility fee and the expected amount of the facility fee.

(c) If a hospital or health system is required to provide a patient with notice under subsection (b) and a patient's admission, procedure or service is scheduled to occur not less than 10 days after the appointment is made, the hospital or health system shall provide written notice and explanation to the patient by first class mail, encrypted electronic means or a secure patient Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled to occur less than 10 days after the appointment is made or if the patient arrives without an appointment, the notice shall be given orally at the time the patient makes the appointment, and written notice shall be provided to the patient prior to the service when the patient arrives at the hospital or provided to the patient on the hospital-based facility's premises.

For emergency care, a hospital or health system shall provide written notice and explanation to the patient prior to the care if practicable, or if notice is not practicable, the hospital or health system shall provide an explanation of the fee to the patient within a reasonable period of time; provided, however, that the explanation of the fee shall be provided before the patient leaves the hospital-based facility. If the patient is incapacitated or otherwise unable to read, understand and act on the patient's rights, the notice and explanation of the fee shall be provided to the patient's representative within a reasonable period of time.

(d) A hospital-based facility shall clearly identify itself as being hospital-based, including by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.



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

(f) (1) If a hospital or health system designates a location as a hospital-based facility, the hospital or health system shall provide written notice of the designation to all patients who received services at the now designated hospital-based facility during the previous calendar year. The written notice shall be provided not later than 30 days after the designation and shall state that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care services delivered at the facility may result in separate bills for services from the hospital and the provider; and (iii) patients seeking care at the facility may incur additional financial liability at that location due its hospital-based facility status.

(2) If a hospital or health system designates a location as a hospital-based facility, the hospital or health system shall not collect a facility fee for a service provided at the now designated hospital-based facility until not less than 30 days after the written notice required in section 28(f)(1) is mailed.

(3) A notice required or provided under section 28(f)(1) or section 28(f)(2) shall be filed with the health policy commission established under section 2 of chapter 6D not later than 30 days after its issuance

(g) The notices and statements required under this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special

knowledge regarding hospital or health system facility fee charges. All notices under this section shall be available in all languages representative of that health care provider's patient population.

(h) A violation of this section shall be an unfair trade practice under chapter 93A.

(i) The commissioner may promulgate regulations that are necessary to implement this section subject to the limitations of section 16A of chapter 6D.

Section 29. (a) As used in this section, "facility fee", "health system", "hospital" and "hospital-based facility" shall have the meanings as provided in section 28.

(b) A carrier 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, 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 otherwise prohibited pursuant to section 51L of chapter 111.

(c) Nothing in this section shall prohibit a carrier from restricting the reimbursement of facility fees beyond the limitations set forth in section 51K of chapter 111.

Section 30. (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) 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 section 30(a)(1).

(a) 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.

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

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

Section 31. (a) The division shall establish a task force to develop recommendations to ensure the current and accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public.

(b) The task force shall consist of the commissioner of insurance or a designee, who shall serve as chair, and 12 members: one of whom shall be a representative of the Massachusetts Association of Health Plans, one of whom shall be a representative of Blue Cross Blue Shield MA, one of whom shall be a representative of the Massachusetts Health and Hospital Association, one of whom shall be a representative of the Massachusetts Medical Society, one of whom shall be a representative of Healthcare Administrative Solutions, Inc., one of whom shall be a representative of the Children's Mental Health Campaign, one of whom shall be a representative of the Massachusetts Association for Mental Health, and five members chosen by the commissioner: one of whom shall have expertise in the treatment of individuals with substance use disorder, one of whom shall have expertise in the treatment of individuals with a mental illness, one of whom shall be from a health consumer advocacy organization, one of whom shall be a consumer representative, and one of whom shall be a representative from an employer group. The task force shall have the ability to form workgroups to develop the recommendations defined in subsection (a).

(c) The recommendations shall include measures for ensuring the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan. The task force shall develop recommendations that establish substantially similar processes and time frames for health care providers included in a carrier's network to provide information to the carrier, and substantially similar processes and timeframes for carriers to include such information in their provider directories, regarding the following:

(1) when a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients, or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;

(2) when a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately if they have not done so already that the provider is not accepting new patients;

(3) when a provider is no longer under contract for a particular network plan;

(4) when a provider's practice location or other information required under this section has changed;

(5) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv) participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility affiliations, if applicable; (xii) languages spoken other than English, if applicable; (xiii) whether accepting new patients; and (xiv) information on access for people with disabilities, including but not limited to structural accessibility and presence of accessible examination and diagnostic equipment;

(6) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location and telephone number; (iv) hospital accreditation status; (7) for facilities, other than hospitals, by

type: (i) facility name; (ii) facility type; (iii) types of services performed; (iv) participating facility location(s) and telephone number; and

(7) Any other information that affects the content or accuracy of the provider directory or directories.

(d) The task force shall develop recommendations for carriers to include information in the provider directory that identifies the tier level for each specific provider, hospital or other type of facility in the network, when applicable.

(e) The task force shall develop recommendations for carriers to include in the provider directories substantially similar language to assist insureds with understanding and searching for behavioral health specialty providers.

(f) The task force shall consider the feasibility of carriers making updates to each online network plan provider directory in real time when health care providers included in a carrier's network provide information to the carrier pursuant to subsection (c).

(g) The task force shall consider measures to address circumstances when an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory.

(h) The task force shall develop recommendations for measures carriers shall take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers, as described in paragraph (c), including but not limited to periodic testing to ensure

that the public interface of the directories accurately reflects the provider network, as required by state and federal laws and regulations.

(i) The task force shall recommend appropriate timelines for completion of its recommendations.

(j) The commissioner shall file the task force's recommendations, including any proposed regulations, with the joint committee on health care financing not later than June 30, 2019.

(k) The commissioner shall promulgate regulations pursuant to section 30 and the recommendations of the task force no later than three months following the commissioner's filing under subsection (j).

(l) The commissioner shall conduct quarterly implementation progress reports, which shall be available to the public, commencing on September 1, 2019 and continuing until the task force recommendations under subsection (j) are fully implemented.

SECTION 12. 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 13. 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 14. The center for health information and analysis shall report on the implementation of facility fee protections under section 28 of chapter 32A, section 51L of chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall include: (i) facility fees charged or billed to provide a baseline report on facility fees that were charged or billed; and (ii) a 5-year status report.

The reports shall include: (i) the number of hospital-based facilities owned or operated by a hospital or health system that provides services for which a facility fee was charged or billed, broken down by hospital or health system; (ii) the number of patient visits provided at each hospital based facility for which a facility fee was charged or billed; (iii) the number of claims, total amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and private insurance policies, including any cost sharing, as applicable; (iv) the total amount of revenue from hospital-based facility fees received by a hospital or health system, categorized by whether a hospital-based facility is on a campus; (v) separately for on-campus and off-campus hospital-based facilities, a description of the 10 procedures or services that generated the greatest amount of facility fee revenue at hospital-based facilities and, for each such procedure or service, the total amount of revenue received by a hospital or health system from the facility fees for the services; and (vi) the top 10 procedures or services for which facility fees were charged based on volume of claims.

510           The center for health information and analysis shall make the information publicly  
511   available on its website. The baseline report shall be made available on December 31, 2020 and  
512   the 5-year status report shall be made available on January 1, 2025.