SENATE DOCKET, NO. 1602 FILED ON: 1/18/2019

SENATE . . . . . No. 659

The Commonwealth of Massachusetts

PRESENTED BY:

James T. Welch

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 access to invaluable, economical, and necessary treatments.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
James T. Welch	*Hampden*	
José F. Tosado	*9th Hampden*	*1/31/2019*
James K. Hawkins	*2nd Bristol*	*2/6/2019*

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SENATE . . . . . No. 659

By Mr. Welch, a 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. Financial Services.

The Commonwealth of Massachusetts

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

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.

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 . Section 10 of chapter 12C of the General Laws, as appearing in the 2016
41 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof
42 the following 2 subsections:-

43 (e) The center, in consultation with the executive office of health and human services,
44 shall develop a process for reporting health care prices and related information from providers
45 for use by consumers, employers and other stakeholders. The center shall develop and
46 periodically update a list of the most common procedures and services and a list of the most
47 common behavioral health services, including outpatient and diversionary mental health and
48 substance use disorder services, based on data collected pursuant to this section and sections 8
49 and 9. The center shall require private and public health care payers to submit the payment rates
50 for procedures and services and other information necessary for the center to determine the rate
51 for every provider with which the payer has contracted or has a compensation arrangement. The
52 center shall make the prices and related information publicly available on the consumer health
53 information website required by section 20. The center shall keep confidential all nonpublic data
54 obtained pursuant to this subsection and shall not disclose such data to any person without the
55 consent of the provider or payer that produced the data; provided, however, that the center may
56 disclose such data in an aggregated format. The center shall promulgate regulations necessary to
57 implement this subsection.

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

61 SECTION 3 . Said chapter 12C is hereby further amended by striking out section 15, as
62 so appearing, and inserting in place thereof the following section:-

63 Section 15. (a) For the purposes of this section, the following words shall have the
64 following meanings unless the context clearly requires otherwise:

65 "Adverse event", harm to a patient resulting from a medical intervention and not the
66 underlying condition of the patient.

67 "Agency", any agency of the executive branch of government in the commonwealth,
68 including but not limited to any constitutional or other office, executive office, department,
69 division, bureau, board, commission or committee thereof; or any authority created by the
70 general court to serve a public purpose with either statewide or local jurisdiction.

71 "Board", the patient safety and medical errors reduction board.

72 "Healthcare-associated infection", an infection that a patient acquires during the course of
73 receiving treatment for another condition within a healthcare setting.

74 "Lehman center", the Betsy Lehman center for patient safety and medical error reduction.

75 "Incident", an incident that, if left undetected or uncorrected, might have resulted in an
76 adverse event.

77 “Medical error”, the failure of medical management of a planned action to be completed
78 as intended or the use of a wrong plan to achieve an outcome.

79 “Patient safety”, freedom from accidental injury.

80 “Patient safety information”, data and information related to patient safety, including
81 adverse events, incidents, medical errors or healthcare-associated infections, that are collected or
82 maintained by agencies.

83 (b) There shall be established within the center the Betsy Lehman center for patient safety
84 and medical error reduction. The Lehman center shall serve as a clearinghouse for the
85 development, evaluation and dissemination, including, but not limited to, the sponsorship of
86 training and education programs, of best practices for patient safety and medical error reduction.
87 The Lehman center shall: (i) coordinate the efforts of state agencies engaged in the regulation,
88 contracting or delivery of health care and those individuals or institutions licensed by the
89 commonwealth to provide health care to meet their responsibilities for patient safety and medical
90 error reduction; (ii) assist such entities to work as part of a total system of patient safety; and (iii)
91 develop appropriate mechanisms for consumers to be included in a statewide program for
92 improving patient safety. The Lehman center shall coordinate state participation in any
93 appropriate state or federal reports or data collection efforts relative to patient safety and medical
94 error reduction. The Lehman center shall analyze available data, research and reports for
95 information that would improve education and training programs that promote patient safety.

96 (c) Within the Lehman center, there shall be established a patient safety and medical
97 errors reduction board. The board shall consist of the secretary of health and human services, the
98 executive director of the center, the director of consumer affairs and business regulations and the

99 attorney general. The board shall appoint, in consultation with the advisory committee, the
100 director of the Lehman center by a unanimous vote and the director shall, under the general
101 supervision of the board, have general oversight of the operation of the Lehman center. The
102 director may appoint or retain and remove expert, clerical or other assistants as the work of the
103 Lehman center may require. The coalition for the prevention of medical errors shall serve as the
104 advisory committee to the board. The advisory committee shall, at the request of the director,
105 provide advice and counsel as it considers appropriate including, but not limited to, serving as a
106 resource for studies and projects undertaken or sponsored by the Lehman center. The advisory
107 committee may also review and comment on regulations and standards proposed or promulgated
108 by the Lehman center, but the review and comment shall be advisory in nature and shall not be
109 considered binding on the Lehman center.

110 (d) The Lehman center shall develop and administer a patient safety and medical error
111 reduction education and research program to assist health care professionals, health care facilities
112 and agencies and the general public regarding issues related to the causes and consequences of
113 medical error and practices and procedures to promote the highest standard for patient safety in
114 the commonwealth. The Lehman center shall annually report to the governor and the general
115 court relative to the feasibility of developing standards for patient safety and medical error
116 reduction programs for any state department, agency, commission or board to reduce medical
117 errors, and the statutory responsibilities of the commonwealth, for the protection of patients and
118 consumers of health care together with recommendations to improve coordination and
119 effectiveness of the programs and activities.

120 (e) The Lehman center shall: (i) identify and disseminate information about evidence-
121 based best practices to reduce medical errors and enhance patient safety; (ii) develop a process

122 for determining which evidence-based best practices should be considered for adoption; (iii)
123 serve as a central clearinghouse for the collection and analysis of existing information on the
124 causes of medical errors and strategies for prevention; and (iv) increase awareness of error
125 prevention strategies through public and professional education. The information collected by the
126 Lehman center or reported to the Lehman center shall not be a public record as defined in section
127 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or
128 introduced into evidence in any judicial or administrative proceeding, except as otherwise
129 specifically provided by law.

130 (f) Notwithstanding any general or special law to the contrary, the Lehman center and
131 each agency that collects or maintains patient safety information may transmit such information,
132 including personal data, as defined in section 1 of chapter 66A, to each other through an
133 agreement, which may be an interagency service agreement, that provides for any safeguards
134 necessary to protect the privacy and security of the information; provided, however, that the
135 provision of the information is consistent with federal law.

136 (g) The Lehman center may adopt rules and regulations necessary to carry out this
137 section. The Lehman center may contract with any federal, state or municipal agency or other
138 public institution or with any private individual, partnership, firm, corporation, association or
139 other entity to manage its affairs or carry out this section.

140 (h) The Lehman center shall report annually to the general court regarding the progress
141 made in improving patient safety and medical error reduction. The Lehman center shall seek
142 federal and foundation support to supplement state resources to carry out the Lehman center's
143 patient safety and medical error reduction goals.

144 SECTION 4 . Said chapter 12C is hereby further amended by inserting after section 20
145 the following section:-

146 Section 20A. The center shall, in collaboration with carriers and consumer
147 representatives, develop a uniform methodology to communicate information on a provider's tier
148 designation for use by patients, purchasers and employers to easily understand the differences
149 between tiered health insurance plans and a provider's tier designation within a tiered health
150 insurance plan.

151 SECTION 5 . Section 4 of chapter 32A of the General Laws, as appearing in the 2016
152 Official Edition, is hereby amended by inserting after the word "commonwealth", in line 12, the
153 following words:- ; provided, however, that the carrier or third-party health care administrator
154 website shall conform to the uniform methodology for a provider's tier designation pursuant to
155 section 20A of chapter 12C.

156 SECTION 6 . Said chapter 32A is hereby further amended by adding the following
157 section:-

158 Section 28. (a) As used in this section, "facility fee", "health system", "hospital" and
159 "hospital-based facility" shall have the same meanings as provided in section 28 of chapter
160 176O.

161 (b) Coverage offered by the commission to an active or retired employee of the
162 commonwealth insured under the group insurance commission shall not impose a separate
163 copayment on an insured or provide reimbursement to a hospital, health system or hospital-based
164 facility for services provided at a hospital, health system or hospital-based facility or for
165 reimbursement to any such hospital, health system or hospital-based facility for a facility fee for

166 services utilizing a current procedural terminology evaluation and management code or which is
167 otherwise limited pursuant to section 51L of chapter 111.

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

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

174 SECTION 7 . Said chapter 94C as appearing in the 2016 Official Edition, is hereby
175 amended by inserting after section 21B the following section:-

176 Section 21C. (a) For the purposes of this section, the following words shall have the
177 following meanings unless the context clearly requires otherwise:

178 "Cost sharing", amounts owed by a consumer under the terms of the consumer's health
179 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit
180 manager as defined in subsection (a) of section 226 of chapter 175.

181 "Pharmacy retail price", the amount an individual would pay for a prescription
182 medication at a pharmacy if the individual purchased that prescription medication at that
183 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any
184 other prescription medication benefit or discount.

185 "Registered pharmacist", a pharmacist who holds a valid certificate of registration issued
186 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

187 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at
188 the point of sale, the current pharmacy retail price for each prescription medication the consumer
189 intends to purchase. If the consumer's cost-sharing amount for a prescription medication exceeds
190 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a
191 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient's cost-
192 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount
193 or the current pharmacy retail price for that prescription medication, as directed by the consumer.

194 A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or
195 a third party for failure to comply with this section.

196 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
197 section; provided, however, that a pharmacist shall submit a claim to the consumer's health
198 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the
199 prescription medication is covered under the consumer's health benefit plan.

200 (d) A violation of this section shall be an unfair or deceptive act or practice under chapter
201 93A.

202 SECTION 8 . Chapter 111, as appearing in the 2016 Official Edition, is hereby amended
203 by inserting after section 51K the following section:-

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

206 "Campus", the physical area immediately adjacent to a hospital's main buildings and
207 other areas and structures that are not strictly contiguous to the main buildings but are located not

208 more than 250 yards from the main buildings or any other area that has been determined on an
209 individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's
210 campus.

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

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

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

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

216 (b) A hospital, health system or hospital-based facility shall not charge, bill or collect a
217 facility fee for services utilizing a current procedural terminology evaluation and management
218 code if the service was provided by a hospital-based facility located off of a campus unless the
219 facility fee was charged, billed or collected by the hospital-based facility on or before July 1,
220 2017. A violation of this subsection shall be an unfair trade practice under chapter 93A.

221 (c) The department may identify additional conditions or factors that would prohibit a
222 hospital, health system or hospital-based facility from charging, billing or collecting a facility fee
223 for health care services. Additional conditions or factors may include, but shall not be limited to:
224 (i) additional current procedural terminology codes for which a hospital, health system or
225 hospital-based facility shall not charge, bill or collect a facility fee; (ii) health care services for
226 which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility
227 fee; (iii) limitations on physical locations, including whether on a campus or not, for which a
228 hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and

229 (iv) other conditions or factors. The department shall forward any recommendations under this
230 subsection to the joint committee on health care financing and the house and senate committees
231 on ways and means.

232 SECTION 9. Said chapter 111 is hereby further amended by inserting after section 70E
233 the following section:-

234 Section 70E1/2. (a) For the purposes of this section, the following words shall, unless the
235 context clearly requires otherwise, have the following meanings:-

236 “Gross charges” means a health care provider’s full, established price for health care
237 services that the health care provider charges patients without health insurance coverage before
238 applying any contractual allowances, discounts, or deductions.

239 "Health care provider", a provider of medical or health services or any other person or
240 organization that furnishes, bills or is paid for health care service delivery in the normal course
241 of business.

242 "Health care services", supplies, care and services of medical, behavioral health,
243 substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic,
244 psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature
245 including, but not limited to, inpatient and outpatient acute hospital care and services; services
246 provided by a community health center home health and hospice care provider, or by a
247 sanatorium, as included in the definition of "hospital" in Title XVIII of the federal Social
248 Security Act, and treatment and care compatible with such services or by a health maintenance
249 organization.

250 "Health insurance coverage" , (any (i) blanket or general policy of medical, surgical or
251 hospital insurance described in subdivision (A), (C) or (D) of section one hundred and ten of
252 chapter one hundred and seventy-five; (ii) policy of accident or sickness insurance as described
253 in section one hundred and eight of chapter one hundred and seventy-five which provides
254 hospital or surgical expense coverage; (iii) nongroup or group hospital or medical service plan
255 issued by a non-profit hospital or medical service corporation under chapters one hundred and
256 seventy-six A and one hundred and seventy-six B; (iv) nongroup or group health maintenance
257 contract issued by a health maintenance organization under chapter one hundred and seventy-six
258 G; (v) insured group health benefit plan that includes a preferred provider arrangement under
259 chapter one hundred and seventy-six I; (vi) self-insured or self-funded employer group health
260 plan; (vii) health coverage provided to persons serving in the armed forces of the United States;
261 (viii) health coverage provided to persons under the Medicare program established by Title
262 XVIII of the Federal Social Security Act; or (ix) medical assistance provided under chapter one
263 hundred and eighteen E.

264 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
265 the University of Massachusetts Medical School or a psychiatric facility licensed under section
266 19 of chapter 19, and any person, agency or organization affiliated with the hospital or by whom
267 services were rendered at the request of the hospital.

268 “Household income” means income calculated by using the methods used to calculate
269 MassHealth eligibility, as set forth in 130 CMR 506.000.

270 "Patient", any natural person receiving health care services from a hospital OR health care
271 provider.

272 "Provider organization", any corporation, partnership, business trust, association or
273 organized group of persons, which is in the business of health care delivery or management,
274 whether incorporated or not that represents 1 or more health care providers in contracting with
275 carriers for the payments of heath care services; provided, that "provider organization" shall
276 include, but not be limited to, physician organizations, physician-hospital organizations,
277 independent practice associations, provider networks, accountable care organizations and any
278 other organization that contracts with carriers for payment for health care services.

279 “Medical debt” a debt arising from the receipt of health care services.

280 (b) Each hospital and health care provider that is a member of a provider organization
281 shall establish a written financial assistance policy. This requirement shall apply whether or not
282 that hospital or health care provider that is a member of a provider organization is required to
283 develop a financial assistance policy under 26 U.S.C. § 501(r)(4).

284 A copy of the financial assistance policy, in plain English and in other languages spoken
285 by patients in that hospital’s or health care provider that is a member of a provider organization’s
286 service area, shall accompany any bill that seeks payment, in whole or in part, for gross charges
287 from that hospital or health care provider that is a member of a provider organization

288 (c) that financial assistance policy shall, at a minimum, contain the following:

289 (1) clearly state that it applies to all health care services delivered by that hospital or
290 health care provider that is a member of a provider organization;

291 (2) a plain language summary of the financial assistance policy, which shall not exceed
292 two pages in length;

293 (3) the eligibility criteria for all financial assistance offered;

294 (4) the method and application process that patients are to use to apply for financial
295 assistance, including but not limited to the name and telephone number of the person or office
296 assigned to work with patients seeking financial assistance;

297 (5) a list of any required documentation that a patient will need to submit with the
298 application for financial assistance;

299 (6) a list of the reasonable steps that the hospital or health care provider will take to
300 determine a patient's eligibility for financial assistance, including but not limited to assisting the
301 patient with applying for and using any health insurance coverage that may be available to them;
302 and

303 (7) the billing and collections policy, including the actions that may be taken in the event
304 of nonpayment, that is consistent with the requirements of this section and other applicable state
305 or federal laws.

306 (d) The financial assistance policy must be approved by the owners or governing body of
307 a hospital and health care provider that is a member of a provider organization, and thereafter
308 shall be reviewed and approved on an annual basis by the owners or governing board.

309 (e) In addition to any other actions required by state or federal law, a hospital and health
310 care provider that is a member of a provider organization shall implement a financial assistance
311 plan for any charges for medically necessary health care services that are not included in the
312 patient's health insurance coverage, if any, and would otherwise be billed to the patient, subject

313 to the requirements of section 228 of this chapter and sections 29 and 30 of chapter 176O, as
314 follows:

315 (1) Patients with household income of 0 per cent through 200 per cent of the federal
316 poverty level shall receive free care;

317 (2) Patients with household income of 201 per cent through 400 per cent of the federal
318 poverty level shall be charged no more than the amount calculated in the following manner:

319 (i) Recalculate the patient's bill using the Medicare reimbursement rate applicable at the
320 time health care services were provided;

321 (ii) The patient shall be charged no more than 50 per cent of the first $1,000 charged
322 under this recalculated bill;

323 (iii) The patient shall be charged no more than 10 per cent of any remaining amount
324 between $1,001–5,000;

325 (iv) The patient shall be charged no more than 5 per cent of any remaining amount
326 between $5,001–10,000;

327 (v) Any amount above $10,000 shall be provided to the patient as free care.

328 (3) Patients with household income of 401 per cent through 600 per cent of the federal
329 poverty level shall receive the same discounts as patients with household income of 201 per cent
330 through 400 per cent of the federal poverty level if the patient and the patient's household can
331 demonstrate though appropriate documentation that they have incurred medical expenses from a
332 hospital or health care provider that is a member of a provider organization during the previous
333 twelve months, the total of which exceeds 10 per cent of the household's annual gross income.

334 (4) In addition to other financial assistance provided under this section, no patient with
335 household income at or below 400 per cent of the federal poverty level shall be required to pay
336 more than $2,300 in cumulative medical bills to a hospital or health care provider that is a
337 member of a provider organization per year. Upon patient request and documentation, any
338 charges for medically necessary health care services that are not included in the patient's health
339 insurance coverage, if any, and would otherwise be billed to the patient, subject to the
340 requirements of section 228 of this chapter and sections 29 and 30 of chapter 176O, that have
341 been delivered by one or more hospitals or health care providers that are a member of a provider
342 organization after the $2,300 limit has been met after applying the limitation of this subsection
343 must be provided as free care.

344 (f) Payments owed for health care services subject to the requirements of subsection (e)
345 shall be interest free.

346 (g) Parents and legal guardians are jointly liable for any medical debt incurred by
347 children under the age of 18.

348 No spouse or other person shall be liable for the medical debt of any other person age 18
349 or older. A person may voluntarily consent to assume liability, but such consent: (1) shall be on
350 a separate standalone document signed by the person; (2) shall not be solicited in an emergency
351 room or an emergency situation; and (3) shall not be a condition of providing any health care
352 services.

353 (h) Nothing in this section shall be construed to diminish or eliminate any protections
354 patients have under existing federal and state debt collection laws, or any other consumer

355 protections available under state or federal law, including but not limited to the Division of
356 Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq.

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

358 SECTION 10. Said chapter 111 is hereby further amended by striking out section 228, as
359 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

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

362 "Allowed amount" shall mean the contractually agreed-upon amount paid by a carrier to
363 a health care provider for health care services provided to an insured.

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

365 "Emergency medical condition", as defined in section 1 of chapter 176O.

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

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

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

372 "Hospital-based facility", a facility that is owned or operated, in whole or in part, by a
373 health care provider, health care provider group or a hospital where health care services are
374 provided.

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

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

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

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

387 “Prior written consent”, a signed written consent form provided to a patient or
388 prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-
389 network provider rendering health care services, other than for emergency services, when said
390 services are scheduled at least 24 hours in advance of the rendering of care, to such patient or
391 prospective patient or, if that person lacks capacity to consent, signed by the person authorized to
392 consent for such a patient or prospective patient. A prior written consent form shall be presented
393 in a manner and format to be determined by the commissioner of public health in consultation
394 with the division of insurance;; provided, that such consent form shall be a document that is
395 separate from any other document used to obtain the consent of the patient or prospective patient
396 for any other part of the care or procedure; and provided further, that such consent form shall

397 include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-
398 network¬ status to the patient or prospective patient; (ii) a statement affirming that the out-of-
399 network provider informed the patient or prospective patient that services rendered by an out-of-
400 network provider may result in costs not covered by the patient's or prospective patient's carrier
401 or specific health benefit plan; (iii) a statement affirming that the out-of-network provider
402 informed the patient or prospective patient that services may be available from a contracted
403 provider and that the patient or prospective patient is not required to obtain care from the out-of-
404 network provider; (iv) a statement affirming that the out-of-network provider presented the
405 patient or prospective patient with a written estimate of the patient or prospective patient's total
406 out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative
407 declaration of the patient's or prospective patient's consent to receive health care services from
408 the out-of-network provider, signed by the patient or prospective patient, or by the person
409 authorized to consent for such a patient or prospective patient.

410 (b) At the time of scheduling an admission, procedure or service for an insured patient or
411 prospective patient, a health care provider shall: (i) determine the provider's own network status
412 relative to insured's insurance carrier and specific health benefit plan and disclose in real time
413 such network status to the insured; (ii) notify the patient or prospective patient of their right to
414 request and obtain from the provider, based on information available to the provider at the time
415 of the request, additional information on the network status of any provider reasonably expected
416 to render services in the course of such admission, procedure or service that is necessary for the
417 patient's or prospective patient's use of a health benefit plan's toll-free number and website
418 available pursuant to section 23 of chapter 176O to obtain additional information about that
419 provider's network status under the patient's or prospective patient's health benefit plan and any

420 applicable out-of-pocket costs for services sought from such provider; (iii) notify the patient or
421 prospective patient of their right to request and obtain from the provider, based on information
422 available to the provider at the time of the request, information on such admission, procedure or
423 service that is necessary for the patient's or prospective patient's use of a health benefit plan's
424 toll-free number and website available pursuant to section 23 of chapter 176O to identify the
425 allowed amount or charge of the admission, procedure or service, including the amount for any
426 facility fees required; (iv) notify the patient or prospective patient that in the event a health care
427 provider is unable to quote a specific allowed amount or charge in advance of the admission,
428 procedure or service due to the health care provider's inability to predict the specific treatment or
429 diagnostic code, the health care provider shall disclose to the patient or prospective patient the
430 estimated maximum allowed amount or charge for a proposed admission, procedure or service,
431 including the amount for any facility fees required; and (iv) inform the patient or prospective
432 patient that the estimated costs and the actual amount the patient or prospective patient may be
433 responsible to pay may vary due to unforeseen services that arise out of the proposed admission,
434 procedure or service. This subsection shall not apply in cases of services provided to a patient to
435 treat an emergency medical condition.

436 (c) If a network provider schedules, orders or otherwise arranges for services related to an
437 insured's admission, procedure or service and such services are performed by another health care
438 provider, or if a network provider refers an insured to another health care provider for an
439 admission, procedure or service, then in addition to the actions required pursuant to subsection
440 (b) the network provider shall, based on information available to the provider at that time: (i)
441 disclose to the insured if the provider to whom the patient is being referred is part of or
442 represented by the same provider organization registered pursuant to section 11 of chapter 6D;

443 (ii) disclose to the insured sufficient information about such provider for the patient to obtain
444 information about that provider's network status under the insured's health benefit plan and
445 identify any applicable out-of-pocket costs for services sought from such provider through the
446 toll-free number and website of the insurance carrier available pursuant to section 23 of chapter
447 176O; and (iii) notify the insured that if the health care provider is out-of-network under the
448 patient's health insurance policy, that the admission, service or procedure will likely be deemed
449 out-of-network and that any out-of-network applicable rates under such policy may apply. This
450 subsection shall not apply in cases of services provided to a patient to treat an emergency
451 medical condition.

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

466 SECTION 11 . Section 1 of chapter 176O of the General Laws, as appearing in the 2016
467 Official Edition, is hereby amended by inserting after the definition of “Incentive plan” the
468 following definition:-

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

472 SECTION 12 . Said section 1 of said chapter 176O, as so appearing, is hereby further
473 amended by inserting after the definition of “Network” the following 3 definitions:-

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

478 “Noncontracted commercial rate for nonemergency services”, the amount set pursuant to
479 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
480 the provision of nonemergency health care services to an insured when the health care provider
481 is not in the carrier’s network.

482 “Nonemergency services”, health care services rendered to an insured experiencing a
483 condition other than an emergency medical condition.

484 SECTION 13 . Said section 1 of said chapter 176O, as so appearing, is hereby further
485 amended by inserting after the definition of “Office of patient protection” the following
486 definition:-

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

493 SECTION 14. Subsection (a) of section 6 of said chapter 176O, as so appearing, is
494 hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

495 (4) the locations where, and the manner in which, health care services and other benefits
496 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or
497 service that is a medically necessary covered benefit is not available to an insured within the
498 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and
499 the insured will not be responsible to pay more than the amount which would be required for
500 similar admissions, procedures or services offered within the carrier's network; and (ii) an
501 explanation that whenever a location is part of the carrier's network, that the carrier shall cover
502 medically necessary covered benefits delivered at that location and the insured shall not be
503 responsible to pay more than the amount required for network services even if part of the
504 medically necessary covered benefits are performed by out-of-network providers unless the
505 insured affirmatively chooses to receive services from an out-of-network provider and the out-of-
506 network provider has obtained the prior written consent of the insured pursuant to section 228 of
507 chapter 111.

508 SECTION 15 . Subsection (a) of said section 6 of said chapter 176O, as so appearing, is
509 hereby further amended by striking out clause (8) and inserting in place thereof the following
510 clause:-

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

516 SECTION 16. Section 23 of said chapter 176O, as so appearing, is hereby amended by
517 striking out section 23, as so appearing in the 2016 2016 Official Edition, and inserting in place
518 thereof the following section:-

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

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

539 The information provided on the website shall conform to the uniform methodology for a
540 provider's tier designation developed pursuant to section 20A of chapter 12C.

541 SECTION 1 7. Said chapter 176O is hereby further amended by adding the following 5
542 sections:-

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

545 "Facility fee", a fee charged or billed by a hospital or health system for outpatient
546 hospital services provided in a hospital-based facility that is intended to compensate the hospital
547 or health system for the operational expenses of the hospital or health system and is separate and
548 distinct from a professional fee.

549 "Health system", shall have the same meaning as "Provider Organization or Health
550 System or System", as provided by the health policy commission.

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

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

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

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

570 (c) If a hospital or health system is required to provide a patient with notice under
571 subsection (b) and a patient's admission, procedure or service is scheduled to occur not less than
572 10 days after the appointment is made, the hospital or health system shall provide written notice

573 and explanation to the patient by first class mail, encrypted electronic means or a secure patient
574 Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled
575 to occur less than 10 days after the appointment is made or if the patient arrives without an
576 appointment, the notice shall be given orally at the time the patient makes the appointment, and
577 written notice shall be provided to the patient prior to the service when the patient arrives at the
578 hospital or provided to the patient on the hospital-based facility's premises.

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

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

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

593 (f) (1) If a hospital or health system designates a location as a hospital-based facility,
594 the hospital or health system shall provide written notice of the designation to all patients who

595 received services at the now designated hospital-based facility during the previous calendar year.
596 The written notice shall be provided not later than 30 days after the designation and shall state
597 that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care
598 services delivered at the facility may result in separate bills for services from the hospital and the
599 provider; and (iii) patients seeking care at the facility may incur additional financial liability at
600 that location due its hospital-based facility status.

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

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

608 (g) The notices and statements required under this section shall be in plain language and
609 in a form that may be reasonably understood by a patient who does not possess special
610 knowledge regarding hospital or health system facility fee charges. All notices under this section
611 shall be available in all languages representative of that health care provider's patient population.

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

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

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

617 (b) A carrier shall not impose a separate copayment on an insured or provide
618 reimbursement to a hospital, health system or hospital-based facility for services provided at a
619 hospital, health system or a hospital-based facility or for reimbursement to such a hospital, health
620 system or hospital-based facility for a facility fee for services utilizing a current procedural
621 terminology evaluation and management code or otherwise prohibited pursuant to section 51L of
622 chapter 111.

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

625 Section 30. (a)(1) A carrier shall reimburse a health care provider as follows:

626 (i) where the health care provider is a member of an insured’s carrier’s network but not a
627 participating provider in the insured’s health benefit plan and the health care provider has
628 delivered health care services to the insured to treat an emergency medical condition, the carrier
629 shall pay that provider the in-network contracted rate for each delivered service; provided,
630 however, that such payment shall constitute payment in full to that health care provider and the
631 provider shall not bill the insured except for any applicable copayment, coinsurance or
632 deductible that would be owed if the insured received such service or services from a
633 participating health care provider under the terms of the insured’s health benefit plan;

634 (ii) where the health care provider is not a member of an insured’s carrier’s network and
635 the health care provider has delivered health care services to the insured to treat an emergency
636 medical condition, the carrier shall pay that provider the noncontracted commercial rate for

637 emergency services for each delivered service; provided, however, that such payment shall
638 constitute payment in full to the health care provider and the provider shall not bill the insured
639 except for any applicable copayment, coinsurance or deductible that would be owed if the
640 insured received such service or services from a participating health care provider under the
641 terms of the insured's health benefit plan;

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

652 (iv) where the health care provider is not a member of an insured's carrier's network and
653 the health care provider has delivered nonemergency services to the insured and a participating
654 provider in the insured's health benefit plan is unavailable or the health care provider renders
655 those nonemergency health care services without the insured's knowledge, the carrier shall pay
656 the provider the noncontracted commercial rate for nonemergency services for each delivered
657 service; provided, however, that such payment shall constitute payment in full to the health care
658 provider and the provider shall not bill the insured except for any applicable copayment,

659 coinsurance or deductible that would be owed if the insured received such service or services
660 from a participating health care provider under the terms of the insured's health benefit plan.

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

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

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

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

672 Section 31 . (a) A carrier shall ensure the accuracy of the information concerning each
673 provider listed in the carrier's provider directories for each network plan and shall review and
674 update the entire provider directory for each network plan. In making the directory available
675 electronically in a searchable format, the carrier shall ensure that the general public is able to
676 view all of the current health care providers for a network plan through a clearly identifiable link
677 or tab and without creating or accessing an account, entering a policy or contract number,
678 providing other identifying information, or demonstrating coverage or an interest in obtaining
679 coverage with the network plan. Thereafter, the carrier shall update each online network plan
680 provider directory at least monthly, or more frequently, if required by state or federal law or

681 regulations promulgated by the commissioner pursuant to Section 32(j), when informed of and
682 upon confirmation by the plan of any of the following:

683 (1) A contracting provider is no longer accepting new patients for that network plan, or
684 an individual provider within a provider group is no longer accepting new patients.

685 (2) A provider or provider group is no longer under contract for a particular network plan.

686 (3) A provider's practice location or other information required under this section has
687 changed.

688 (4) Upon completion of the investigation described in paragraph (a)(4), a change is
689 necessary based on an enrollee complaint that a provider was not accepting new patients, was
690 otherwise not available, or whose contact information was listed incorrectly.

691 (5) A provider has retired or otherwise has ceased to practice.

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

694 (b) A provider directory shall not list or include information on a provider that is not
695 currently under contract with the network plan.

696 (c) A carrier shall periodically audit its provider directories for accuracy and retain
697 documentation of such an audit to be made available to the commissioner upon request.

698 (d) A carrier shall provide a print copy, or a print copy of the requested directory
699 information, of a current provider directory upon request of an insured or a prospective insured.
700 The printed copy of the provider directory or directories shall be provided to the requester by

701 mail postmarked no later than five business days following the date of the request and may be
702 limited to the geographic region in which the requester resides or works or intends to reside or
703 work.

704 (e) The carrier shall include in both its electronic and print directories a dedicated
705 customer service email address and telephone number or electronic link that insureds, providers
706 and the general public may use to notify the carrier of inaccurate provider directory information.
707 This information shall be disclosed prominently in the directory or directories and on the
708 carrier's web site. The carrier shall be required to investigate reports of inaccuracies within 30
709 days of notice and modify the directories in accordance with any findings within 30 days of such
710 findings.

711 (f) The provider directory or directories shall inform enrollees and potential enrollees that
712 they are entitled to: (A) language interpreter services, at no cost to the enrollee; and (B) full and
713 equal access to covered services as required under the federal Americans with Disabilities Act of
714 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in
715 electronic or print format, shall accommodate the communication needs of individuals with
716 disabilities, and include a link to or information regarding available assistance for persons with
717 limited English proficiency, including how to obtain interpretation and translation services.

718 (g) The carrier shall include a disclosure in the print directory that the information
719 included in the directory is accurate as of the date of printing and that insureds or prospective
720 insureds should consult the carrier's electronic provider directory on its website or call a
721 specified customer service telephone number to obtain the most current provider directory
722 information.

723 (h) The carrier shall update its printed provider directory or directories at least annually,
724 or more frequently, if required by federal law or regulations promulgated by the commissioner.

725 Section 32. (a) The division shall establish a task force to develop recommendations to
726 ensure the current and accurate electronic posting of carrier provider directories in a searchable
727 format for each of the carriers' network plans available for viewing by the general public.

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

742 (c) The recommendations shall include measures for ensuring the accuracy of
743 information concerning each provider listed in the carrier's provider directories for each network
744 plan. The task force shall develop recommendations that establish substantially similar processes

745 and time frames for health care providers included in a carrier's network to provide information
746 to the carrier, and substantially similar processes and timeframes for carriers to include such
747 information in their provider directories, regarding the following:

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

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

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

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

760 (5) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv)
761 participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas
762 of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical
763 group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility
764 affiliations, if applicable; (xii) languages spoken other than English, if applicable; (xiii) whether
765 accepting new patients; and (xiv) information on access for people with disabilities, including

766 but not limited to structural accessibility and presence of accessible examination and diagnostic
767 equipment;

768 (6) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location
769 and telephone number; (iv) hospital accreditation status; (7) for facilities, other than hospitals, by
770 type: (i) facility name; (ii) facility type; (iii) types of services performed; (iv) participating
771 facility location(s) and telephone number; and

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

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

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

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

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

786 (h) The task force shall develop recommendations for measures carriers shall take to
787 ensure the accuracy of the information concerning each provider listed in the carrier's provider
788 directories for each network plan based on the information provided to the carriers by network
789 providers, as described in paragraph (c), including but not limited to periodic testing to ensure
790 that the public interface of the directories accurately reflects the provider network, as required by
791 state and federal laws and regulations.

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

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

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

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

802 SECTION 1 8. Notwithstanding any general or special law to the contrary, the
803 noncontracted commercial rate for nonemergency services under chapter 176O of the General
804 Laws shall be not more than the eightieth percentile of all allowed charges for a particular health
805 care service performed by a health care provider in the same or similar specialty and provided in
806 the same geographical area, as reported in a benchmarking database by a nonprofit organization

807 specified by the division of insurance. Such an organization shall not be affiliated with a health
808 carrier.

809 SECTION 19. Notwithstanding any general or special law to the contrary, the
810 noncontracted commercial rate for emergency services under chapter 176O of the General Laws
811 shall be not more than the eightieth percentile of all allowed charges for a particular health care
812 service performed by a health care provider in the same or similar specialty and provided in the
813 same geographical area, as reported in a benchmarking database by a nonprofit organization
814 specified by the division of insurance. Such an organization shall not be affiliated with any
815 health carrier.

816 SECTION 20 . Sections 18 and 19 are hereby repealed.

817 SECTION 21 . The center for health information and analysis shall report on the
818 implementation of facility fee protections under section 28 of chapter 32A, section 51L of
819 chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall
820 include: (i) facility fees charged or billed to provide a baseline report on facility fees that were
821 charged or billed; and (ii) a 5-year status report.

822 The reports shall include: (i) the number of hospital-based facilities owned or operated by
823 a hospital or health system that provides services for which a facility fee was charged or billed,
824 broken down by hospital or health system; (ii) the number of patient visits provided at each
825 hospital based facility for which a facility fee was charged or billed; (iii) the number of claims,
826 total amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and
827 private insurance policies, including any cost sharing, as applicable; (iv) the total amount of
828 revenue from hospital-based facility fees received by a hospital or health system, categorized by

829 whether a hospital-based facility is on a campus; (v) separately for on-campus and off-campus
830 hospital-based facilities, a description of the 10 procedures or services that generated the greatest
831 amount of facility fee revenue at hospital-based facilities and, for each such procedure or service,
832 the total amount of revenue received by a hospital or health system from the facility fees for the
833 services; and (vi) the top 10 procedures or services for which facility fees were charged based on
834 volume of claims.

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

838 SECTION 22 . Section 1 shall apply to plans submitted to the division of insurance on or
839 after January 1, 2021.

840 SECTION 23 . Section 20 shall take effect on December 31, 2020.

841 SECTION 2 4. Notwithstanding any general or special law to the contrary, carriers shall
842 ensure the accuracy of the information pursuant to the regulations issued by the commissioner of
843 insurance pursuant to section 31 of chapter 176O of the general laws for each network plan no
844 later than January 1, 2020.