SENATE DOCKET, NO. 2149 FILED ON: 2/19/2021

SENATE . . . . . No. 680

The Commonwealth of Massachusetts

PRESENTED BY:

Adam Gomez

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 relative to out of network billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Adam Gomez	*Hampden*

SENATE DOCKET, NO. 2149 FILED ON: 2/19/2021

SENATE . . . . . No. 680

By Mr. Gomez, a petition (accompanied by bill, Senate, No. 680) of Adam Gomez for legislation relative to out of network billing. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act relative to out of network billing.

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

SECTION 1. Section 1 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of “Emergency medical condition” the following definition:

"Emergency services", health care services rendered to treat an emergency medical condition.

SECTION 2. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Incentive plan” the following 2 definitions:

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

“In-network cost-sharing amount”, the cost-sharing amount that the insured is required to pay for a covered health care service received from a network provider. Cost sharing includes

any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

SECTION 3. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following 2 definitions:

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

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

SECTION 4. 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 facility”, a facility that does not participate in the network of an insured’s health benefit plan.

“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 5. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Adverse determination” the following definition:

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

SECTION 6. Said chapter 176O of the General Laws is hereby further amended by adding the following 5 sections:

Section 28. (a) For purposes of this section, an item or service furnished by an out-of-network provider during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, the total amount payable under such a plan, coverage, or issuer, respectively in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such an out-of-network provider, shall be paid in accordance with the determination of the qualifying payment amount as applicable under this section.

(b) The term ‘qualifying payment amount’ means, subject to subsections (c) and (d), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage—

(1) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively, determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance

market as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established under Section 2799A – 1 (a)(2)(B) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(2) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this section for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(c) The term ‘qualifying payment amount’ means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(1) for the first year in which such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with the methodology established under subsection (b) above) for items and services that are covered by such plan or coverage and furnished during such first year; and

(2) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this section for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(d) In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in subsection (b)(1) in 2019 (or, in the case of a newly covered item or service (as defined in subsection (f)(iii)), in the first coverage year (as defined in subsection (f)(1))) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services provided in a particular geographic region (other than in a case with respect to which subsection (c) applies)) the term 'qualifying payment amount'—

(1) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined not to have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region;

(2) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in subsection (f)(2)) for such item or service with respect to such plan or coverage), means the rate determined under subsection (b) or this subsection, as

applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(3) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in subsection (b)(1), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(4) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (c)(ii), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(e) For purposes of subsection (b)(1), a health insurance market specified in this subsection is one of the following:

(1) The individual market.

(2) The large group market (other than plans described in paragraph (4)).

(3) The small group market (other than plans described in paragraph (4)).

(4) In the case of a self-insured group health plan, other self-insured group health plans.

(f) For purposes of this section:

(1) The term ‘first coverage year’ means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(2) The term ‘first sufficient information year’ means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(A) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in subsection (b)(1) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(B) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in subsection (b)(1) in the year previous to such first subsequent year.

(3) The term ‘newly covered item or service’ means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(g) An out-of-network provider who, on a case-by-case basis, determines to waive a cost for an insured in a health benefit plan based upon economic circumstances of the insured,

including any deductible, copayment, or coinsurance amount, shall, for such action, not be subject to any of the following:

(1) a civil cause of action by a health benefit plan,

(2) prosecution for a violation of this chapter in a court of competent jurisdiction,

(3) a sanction before any state oversight or licensing board, or

(4) an approval requirement of a health benefit plan.

Section 29. (a) If a carrier provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the carrier shall cover emergency services—

(1) without the need for any prior authorization determination;

(2) whether the health care provider furnishing such services is a network provider with respect to such services;

(3) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by an out-of-network provider—

(A) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers with respect to such plan or coverage, respectively;

(B) the cost-sharing requirement is not greater than the in-network cost-sharing amount;

(C) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such network provider were equal to the qualifying payment amount for such services, plan or coverage, and year;

(D) the carrier—

(i) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

(ii) pays a total plan or coverage payment directly to such provider or facility, respectively that is, with application of any initial payment under subclause (I), equal to the amount by which the qualifying payment amount for such services exceeds the cost-sharing amount for such services (as determined in accordance with subsections (B) and (C)) and year

(E) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of- pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a network provider; and

(4) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under 29 CFR § 2590.715-2704, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

Section 30. (a) With respect to an item or service furnished in a year by an out-of-network provider, with respect to a carrier offering group or individual health insurance coverage, with respect to such carrier or coverage and provider or facility, and for which a payment is required to be made by the carrier or coverage, the provider or facility (as applicable) or carrier or coverage may, during the 15-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and carrier or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such carrier or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 15-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(b) In the case of open negotiations pursuant to subsection (a), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subsection with respect to such item or service, the provider or facility (as applicable) or carrier offering group or individual health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under subsection (c) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party of a notification (containing such information as specified under subsection (c)) and for purposes of this subsection, the date of initiation of such process shall be the date of such

submission or such other date specified pursuant to regulations that is not later than the date of receipt of such notification by the other party.

(c) In the case of an item or service with respect to which a provider or facility (as applicable) or group health plan submits a notification under subsection (b) (in this Section referred to as a 'qualified IDR item or service'), a certified IDR entity under Section 2799A–1 (c) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) shall determine the amount of payment under the plan for such item or service furnished by such provider or facility.

(d) Under the IDR process as established by Section 2799A–1 (c)(1)(A)(2) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the IDR entity selected makes a determination under subsection (c), such amount shall be treated as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(e) Under the IDR process as established by Section 2799A–1 (c)(1)(A)(2) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), multiple qualified IDR items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if—

(1) such items and services to be included in such determination are furnished by the same provider or facility;

(2) payment for such items and services is required to be made by the same carrier; and

(3) such items and services are related to the treatment of a similar condition.

(f) In carrying out subsection (e), in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this section.

(g) Entities shall be certified for participation in the IDR process in accordance with Section 2799A–1 (c)(4) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.).

(h) Selection of a certified IDR entity shall be done jointly by the parties to the IDR process in conformance with the process established under Section 2799A–1 (c)(4)(F) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.).

(i) Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

(1) taking into account the considerations specified in subsection (k), select one of the offers submitted under subsection (j) to be the amount of payment for such item or service determined under this section, as applicable; and

(2) notify the parties to such determination of the offer selected under subsection (i)(1).

(j) Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the carrier party to such determination—

(1) shall each submit to the certified IDR entity with respect to such determination—

(A) an offer for a payment amount for such item or service furnished by such provider or facility; and

(B) such information as requested by the certified IDR entity relating to such offer; and

(2) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subsection (k).

(k) In determining which offer is the payment to be applied pursuant to this section, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

(1) the qualifying payment amounts for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region as such qualified IDR item or service; and

(2) subject to subsection (m), information on any circumstance described in subsection (l), such information as requested in subsection (j)(1)(B), and any additional information provided in subsection (j)(2).

(l) For purposes of this subsection, the circumstances described in this subsection are, with respect to a qualified IDR item or service of an out-of-network provider or carrier the following:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(3) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(4) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(5) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(m) In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of this section (as applicable) not applied, or the payment or reimbursement rate for such items and

services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or under chapter 17 of title 38, United States Code.

(n) A determination of a certified IDR entity under subsection (i)—

(1) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(2) shall not be subject to judicial review, except in a case where:

(A) the determination was procured by corruption, fraud, or undue means;

(B) there was evident partiality or corruption in the IDR entity;

(C) the IDR entity was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or

(D) the IDR entity exceeded its powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

(o) If an IDR entity makes a determination with respect to such notification under subsection (b), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and if the parties reach a settlement with respect to

such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(p) The total plan or coverage payment required pursuant to this section, with respect to a qualified IDR item or service for which a determination is made under subsection (i) or with respect to an item or service for which a payment amount is determined under open negotiations under subsection (a), shall be made directly to the out-of-network provider not later than 15 days after the date on which such determination is made.

Section 31. (a) Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a Carrier and who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which Section 1 applies) for which benefits are provided under the plan or coverage at a network facility by an out-of-network provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the in-network cost-sharing amount for such item or service.

(b) Subsection (a) shall not apply with respect to items or services (other than ancillary services described in subsection (c)) furnished by an out-of-network provider to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (f).

(c) For purposes of subsection (b), ancillary services described in this subsection are, with respect to an in-network facility—

(1) subject to subsection (d), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(2) subject to subsection (d), diagnostic services (including radiology and laboratory services);

(3) items and services provided by such other specialty practitioners, as specified through rulemaking established under Section 2799B–2 of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.); and

(4) items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

(d) As established under Section 2799B–2 of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) certain advanced diagnostic laboratory tests shall not be included as an ancillary service described in subsection (c) and with respect to which subsection (a) would apply.

(e) In the case of an out-of-network provider or facility, who satisfies the notice and consent criteria of subsection (f) with respect to an item or service (referred to in this subsection as a ‘covered item or service’), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the

previous sentence, a covered item or service shall not include an ancillary service described in subsection (c).

(f) An out-of-network provider or facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or facility—

(1) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 7 days prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior to the date on which the individual is furnished such items or services (or, in the case that the participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant, beneficiary, or enrollee, (and including electronic notification, as practicable) that—

(A) contains the information required under subsection (g);

(B) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing

responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and

(C) is available in the 15 most common languages in the geographic region of the applicable facility;

(2) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in subsection (h) to be treated by a nonparticipating provider or nonparticipating facility; and

(3) provides a signed copy of such consent to the participant, beneficiary, or enrollee through mail or email (as selected by the participant, beneficiary, or enrollee).

(g) For purposes of subsection (f)(1)(A), the information described in this subsection, with respect to an out-of-network provider or facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, is each of the following:

(1) Notification, as applicable, that the health care provider is an out-of-network provider with respect to the health plan or the health care facility is out-of-network with respect to the health plan.

(2) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under subsection (h) does not constitute a contract with respect to the charges estimated for such items and services.

(3) In the case of an in-network facility and an out-of-network provider, a list of any in-network providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

(4) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

(h) For purposes of subsection (f)(2), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by an out-of-network provider or facility, is a document specified under Section 2799B–2 (d)(3) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that —

(1) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—

(A) provided with the written notice under paragraph (f)(1);

(B) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

(C) provided the opportunity to receive the written notice under paragraph (f)(1) in the form selected by the participant, beneficiary or enrollee; and

(2) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (f)(1) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility.

(i) The consent described in subsection (h), with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

Section 32. (a) A Carrier offering a plan(s) that includes a Network(s) shall maintain such Network(s) such that it is adequate in numbers and types of Providers to assure that all covered services will be accessible to all Insureds without unreasonable delay. Adequacy shall be determined through consideration of whether the Network includes a sufficient number of contracted providers of emergency services and surgical or ancillary services at or for the Carrier's contracted in-network hospitals to reasonably ensure that enrollees have in-network access to covered benefits delivered at that facility.

(b) The Commissioner shall adopt rules for a health carrier's network adequacy. Such rules shall establish, but not be limited to:

(1) waiting times for appointments for non-emergency care;

(2) choice of and access to providers for specialty care, specifically addressing the needs of the chronically ill, mentally ill, persons with substance use disorder, developmentally disabled or those with a life-threatening illness;

(3) standards for geographic accessibility, which shall include standards for access to the provision of durable medical equipment requiring a prescription. However, such standards shall not restrict an insurer's ability to provide prescriptions for durable medical equipment that are shipped to the patient by postal service or other common or private carrier, and shall not apply to durable medical equipment devices used exclusively for the administration of medication;

(4) hours of operation for the carrier, including any entities performing prior approval or pre-authorization functions; and

(5) standards for addressing in-network access to hospital-based surgical and ancillary service providers, such as anesthesiologists, radiologists, pathologists, and emergency medicine physicians.

(c) Carriers shall maintain a Network of providers that includes but is not limited to Providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.

SECTION 7. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby amended by striking out clauses 14 and 15 and inserting in place thereof the following:-

(14) the toll-free telephone number, facsimile number, and internet site for the office of patient protection or, if applicable, the designated state consumer assistance program;

(15) a statement identifying whether the health benefit plan is subject to state law or the Employee Retirement Income Security Act; and

(16) such other information as the commissioner may by regulation require.