HOUSE DOCKET, NO. 2468 FILED ON: 1/19/2023

HOUSE . . . . . No. 997

The Commonwealth of Massachusetts

PRESENTED BY:

Paul J. Donato

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to protect health care consumers from surprise billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Paul J. Donato	*35th Middlesex*	*1/19/2023*
Dylan A. Fernandes	*Barnstable, Dukes and Nantucket*	*7/20/2023*

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HOUSE . . . . . No. 997

By Representative Donato of Medford, a petition (accompanied by bill, House, No. 997) of Paul J. Donato relative to non-contracted and non-emergency healthcare billing. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1066* OF 2021-2022.]

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act to protect health care consumers from surprise billing.

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

SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting after section 51K the following 2 sections:-

Section 51L. (a) As used in this section and section 51M, the following terms shall have the following meanings:-

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

"Facility fee", a fee charged, billed or collected by a health care provider for hospital services provided in a facility that is owned or operated, in whole or in part, by a hospital or

health system that is intended to compensate the health care provider for operational expenses and is separate and distinct from a professional fee.

"Health care provider", shall have the same meaning as in section 1 of chapter 6D.

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

"Professional fee", a fee charged or billed by a health care provider for professional medical services.

(b) A health care provider shall not charge, bill or collect a facility fee except for: (i) services provided on a hospital's campus; (ii) services provided at a facility that includes a licensed hospital emergency department; or (iii) emergency services provided at a licensed satellite emergency facility.

(c) Notwithstanding subsection (b), a health care provider shall not charge, bill, or collect a facility fee for a service identified by the commission pursuant to its authority in section 20 of chapter 6D as a service that may reliably be provided safely and effectively in settings other than hospitals.

(d) The department may promulgate regulations necessary to implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant hereto shall be punished by a fine of not more than $1,000 per occurrence.

Section 51M. (a) If a health care provider charges or bills a facility fee for services, the health care provider shall provide any patient receiving such service with written notice that such a fee will be charged and may be billed separately.

(b) If a health care provider is required to provide a patient with notice under subsection (a) and a patient's appointment is scheduled to occur not less than 10 days after the appointment is made, the health care provider shall provide written notice and explanation to the patient by first class mail, encrypted electronic means or a secure patient Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled to occur less than 10 days after the appointment is made or if the patient arrives without an appointment, the notice shall be provided to the patient on the facility's premises.

If a patient arrives without an appointment, a health care provider shall provide written notice and explanation to the patient prior to the care if practicable, or if prior notice is not practicable, the health care provider shall provide an explanation of the fee to the patient within a reasonable period of time; provided, however, that the explanation of the fee shall be provided before the patient leaves the facility. If the patient is incapacitated or otherwise unable to read, understand and act on the patient's rights, the notice and explanation of the fee shall be provided to the patient's representative within a reasonable period of time.

(c) A facility at which facility fees for services are charged, billed, or collected shall clearly identify itself as being associated with a hospital, including by stating the name of the hospital that owns or operates the location in its signage, marketing materials, Internet web sites, and stationery.

(d) If a health care provider charges, bills, or collects facility fees at a given facility, notice shall be posted in that facility informing patients that a patient may incur higher financial liability as compared to receiving the service in a non-hospital facility. Notice shall be prominently displayed in locations accessible to and visible by patients, including in patient waiting areas.

(e)(1) If a location at which health care services are provided without facility fees changes status such that facility fees would be permissible at that location under section 51L, and the health care provider that owns or operates the location elects to charge, bill, or collect facility fees, the health care provider shall provide written notice to all patients who received services at the location during the previous calendar year not later than 30 days after the change of status. The notice shall state that: (i) the location is now owned or operated by a hospital; (ii) certain health care services delivered at the facility may result in separate facility and professional bills for services; and (iii) patients seeking care at the facility may incur higher financial liability at that location due to its change in status.

(2) In cases in which a written notice is required by paragraph (1), the health care provider that owns or operates the location shall not charge or bill a facility fee for services provided at that location until not less than 30 days after the written notice is provided.

(3) A notice required or provided under paragraph (1) shall be filed with the department not later than 30 days after its issuance.

(f) The department may promulgate regulations necessary to implement this section and impose penalties for non-compliance consistent with the department’s authority to regulate health care providers. A health care provider that violates any provision of this section or the

rules and regulations adopted pursuant hereto shall be punished by a fine of not more than $1,000 per occurrence. In addition to any penalties for noncompliance that may be established by the department, a violation of this section shall be an unfair trade practice under chapter 93A.

SECTION 2. Section 228 of said chapter 111 of the General Laws is hereby amended by striking out subsection (e) and inserting in place thereof the following subsection:-

(e) A health care provider shall determine if it participates in a patient's health benefit plan prior to said patient's admission, procedure or service for conditions that are not emergency medical conditions as defined in section 1 of chapter 176O. If the health care provider does not participate in the patient's health benefit plan and the admission, procedure or service was scheduled more than 7 days in advance of the admission, procedure or service, such provider shall notify the patient verbally and in writing of that fact not less than 7 days before the scheduled admission, procedure or service. If the health care provider does not participate in the patient's health benefit plan and the admission,

procedure or service was scheduled less than 7 days in advance of the admission, procedure or service, such provider shall notify the patient verbally of that fact not less than 2 days before the scheduled admission, procedure or service or as soon as is practicable before the scheduled admission, procedure or service, with written notice of that fact to be provided upon the patient's arrival at the scheduled admission, procedure or service. If a health care provider that does not participate in the patient's health benefit plan fails to provide the required notifications under this subsection, or if the provider is rendering unforeseen out-of-network services, as defined in subsection (a) of section 30 of chapter 176O, the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be payable if

the insured received the service from a participating health care provider under the terms of the insured's health benefit plan. Nothing in this subsection shall relieve a health care provider from the requirements under subsections (b) to (d), inclusive.

SECTION 3. Section 1 of chapter 175H of the General Laws is hereby amended by adding the following definitions:-

"Impermissible facility fee," a facility fee, as defined in section 51L of chapter 111, that is not charged, billed or collected in accordance with paragraphs (b) or (c) of said section 51L of said chapter 111.

"Surprise bill," a bill received by an insured for unforeseen out-of-network services, as defined in section 30 of chapter 176O.

SECTION 4. Said chapter 175H of the General Laws is hereby further amended by striking out sections 5 and 6 and inserting in place thereof the following sections:-

Section 5. The attorney general may conduct an investigation of an alleged violation of this chapter and may commence a proceeding pursuant to section 4. Additionally, the attorney general has the authority to initiate a civil action under this chapter. When the attorney general has determined that a provider has violated this chapter, the attorney general shall notify the department of public health, the department of mental health, the board of registration in medicine or any other relevant licensing authorities, of that determination. Those licensing authorities may, upon their own investigation or upon notification from the attorney general that a provider licensed by that authority has violated this section, impose penalties for non-compliance consistent with their authority to regulate those providers.

Section 6. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity, which such person knows that he or she is not entitled to receive or be paid, or a person who knowingly presents or causes to be presented with fraudulent intent a claim which contains a false statement, including but not limited to a payment or false statement regarding an impermissible facility fee shall be liable to the health care corporation or health care insurer or other person or entity for the full amount of the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care corporation or health care insurer or other injured person or entity may bring a civil action under this chapter in the superior court department of the trial court.

Section 6A. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity shall not be permitted to forward a surprise bill to a person covered under an insured health plan. A person who violates this section shall be liable to the health care corporation or health care insurer or other person or entity for penalties and for

reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care corporation or health care insurer or other injured person or entity may bring a civil action under this chapter in the superior court department of the trial court.

SECTION 5. Chapter 176O of the General Laws is hereby amended by adding the following section:-

Section 30. (a) As used in this section, "unforeseen out-of-network service" shall mean the following: (1) health care services rendered by an out-of-network provider for emergency medical conditions, including post-stabilization services resulting from an emergency medical

condition; (2) non-emergency health care services rendered by an out-of-network provider at an in-network facility, including but not limited to: (i) services for emergency medicine, anesthesiology, pathology, radiology, or neonatology, or services rendered by assistant surgeons, hospitalists, and intensivists; (ii) health care services rendered by an out-of-network provider without the insured's advanced knowledge, pursuant to the requirements set forth in subsections (b) through (e) of section 228 of chapter 111; (iii) health care services provided by an out-of-network provider if there is no in-network provider who can furnish such health care service at such facility; (iv) health care services rendered by an out-of-network provider, including an out-of-network laboratory, radiologist, or pathologist, where the health care services were referred, or an insured's specimen was sent, by a participating provider to an out-of-network provider; or (v) unforeseen health care services that arise at the time health care services are rendered that must necessarily be rendered by an out-of-network provider; and (3) health care services delivered by an ambulance service provider licensed by the department of public health pursuant to section 6 of chapter 111C.

(b) An insured shall only be required to pay an out-of-network provider who renders an unforeseen out-of-network service the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if the service was rendered by a participating provider. Payments made by an insured pursuant to this section shall count towards any in-network deductible or out-of-pocket maximum pursuant to the terms and conditions of an insured's health benefit plan.

(c) A carrier shall reimburse an out-of-network provider who renders an unforeseen out-of-network service to an insured at the carrier's median contracted rate for that service in the geographic region in the relevant market. Such payment shall constitute payment in full to the

out-of-network provider and the out-of-network provider shall not bill the insured for any amount except for any in-network cost sharing amount owed for such service.

(d) With respect to an entity providing or administering a self-funded health benefit plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. and its plan members, this section shall only apply if the plan elects to be subject to the provisions of this section. To elect to be subject to the provisions of this section, the self-funded health benefit plan shall provide notice to the division on an annual basis, in a form and manner prescribed by the division, attesting to the plan's participation and agreeing to be bound by the provisions of this section. The self-funded health benefit plan shall amend the health benefit plan, coverage policies, contracts and any other plan documents to reflect that the benefits of this section shall apply to the plan's members.

(e) This section shall not be construed to require a carrier to cover health care services not required by law or by the terms and conditions of an insured's health benefit plan. Nothing in this section shall require a carrier to pay for health care services delivered to an insured that are not covered benefits under the terms of the insured's health benefit plan.

(f) Nothing in this section shall require a carrier to pay for nonemergency services delivered to an insured if the insured had a reasonable opportunity to choose to have the service performed by a network provider participating in the insured's health benefit plan. Evidence that an insured had a reasonable opportunity to choose to have the service performed by a participating provider may include, but not be limited to, a consent waiver signed by the insured.

(g) The commissioner shall promulgate regulations to implement this section.