

**HOUSE . . . . . No.**

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**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:
<i>Paul J. Donato</i>	<i>35th Middlesex</i>	<i>1/14/2025</i>

**HOUSE . . . . . No.**

[Pin Slip]

**The Commonwealth of Massachusetts**

**In the One Hundred and Ninety-Fourth General Court  
(2025-2026)**

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:*

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

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

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

9 “Facility fee”, a fee charged, billed or collected by a health care provider for hospital  
10 services provided in a facility that is owned or operated, in whole or in part, by a hospital or  
11 health system that is intended to compensate the health care provider for operational expenses  
12 and is separate and distinct from a professional fee.

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

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

15 “Professional fee”, a fee charged or billed by a health care provider for professional  
16 medical services.

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

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

25 (d) The department shall promulgate regulations necessary to implement this section and  
26 impose penalties for non-compliance consistent with the department’s authority to regulate  
27 health care providers. A health care provider that violates any provision of this section or the  
28 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than  
29 \$1,000 per occurrence.

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

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

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

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

51 (d) If a health care provider charges, bills, or collects facility fees at a given facility,  
52 notice shall be posted in that facility informing patients that a patient may incur higher financial  
53 liability as compared to receiving the service in a non-hospital facility. Notice shall be

54 prominently displayed in locations accessible to and visible by patients, including in patient  
55 waiting areas.

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

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

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

70 (f) The department may promulgate regulations necessary to implement this section and  
71 impose penalties for non-compliance consistent with the department's authority to regulate  
72 health care providers. A health care provider that violates any provision of this section or the  
73 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than  
74 \$1,000 per occurrence. In addition to any penalties for noncompliance that may be established by  
75 the department, a violation of this section shall be an unfair trade practice under chapter 93A.

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

78 (e) A health care provider shall determine if it participates in a patient's health benefit  
79 plan prior to said patient's admission, procedure or service for conditions that are not emergency  
80 medical conditions as defined in section 1 of chapter 176O. If the health care provider does not  
81 participate in the patient's health benefit plan and the admission, procedure or service was  
82 scheduled more than 7 days in advance of the admission, procedure or service, such provider  
83 shall notify the patient verbally and in writing of that fact not less than 7 days before the  
84 scheduled admission, procedure or service. If the health care provider does not participate in the  
85 patient's health benefit plan and the admission, procedure or service was scheduled less than 7  
86 days in advance of the admission, procedure or service, such provider shall notify the patient  
87 verbally of that fact not less than 2 days before the scheduled admission, procedure or service or  
88 as soon as is practicable before the scheduled admission, procedure or service, with written  
89 notice of that fact to be provided upon the patient's arrival at the scheduled admission, procedure  
90 or service. If a health care provider that does not participate in the patient's health benefit plan  
91 fails to provide the required notifications under this subsection, or if the provider is rendering  
92 unforeseen out-of-network services, as defined in subsection (a) of section 30 of chapter 176O,  
93 the provider shall not bill the insured except for any applicable copayment, coinsurance or  
94 deductible that would be payable if the insured received the service from a participating health  
95 care provider under the terms of the insured's health benefit plan. Nothing in this subsection  
96 shall relieve a health care provider from the requirements under subsections (b) to (d), inclusive.

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

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

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

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

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

116           Section 6. A person who receives a health care benefit or payment from a health care  
117 corporation or health care insurer or other person or entity, which such person knows that he or  
118 she is not entitled to receive or be paid, or a person who knowingly presents or causes to be  
119 presented with fraudulent intent a claim which contains a false statement, including but not  
120 limited to a payment or false statement regarding an impermissible facility fee shall be liable to

121 the health care corporation or health care insurer or other person or entity for the full amount of  
122 the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of  
123 investigation. A health care corporation or health care insurer or other injured person or entity  
124 may bring a civil action under this chapter in the superior court department of the trial court.

125         Section 6A. A person who receives a health care benefit or payment from a health care  
126 corporation or health care insurer or other person or entity shall not be permitted to forward a  
127 surprise bill to a person covered under an insured health plan. A person who violates this section  
128 shall be liable to the health care corporation or health care insurer or other person or entity for  
129 penalties and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A  
130 health care corporation or health care insurer or other injured person or entity may bring a civil  
131 action under this chapter in the superior court department of the trial court.

132         SECTION 5. Chapter 176J of the General Laws is hereby amended by inserting after  
133 section 17 the following new section:-

134         Section 18. Carriers shall reimburse evaluation and management services delivered by an  
135 off-campus hospital outpatient department, clinic, ambulatory surgical center, or stand-alone  
136 emergency department, and ambulatory services commonly provided in office-based settings,  
137 including but not limited to laboratory tests, imaging, and diagnostic services, and clinician-  
138 administered drugs that are identified by the health policy commission, as equivalent to the non-  
139 facility rate in the Medicare physician fee schedule that applies to physician offices.

140         SECTION 6. Chapter 176O of the General Laws is hereby amended by inserting after  
141 section 29 the following section:-

142           Section 30. (a) As used in this section, “unforeseen out-of-network service” shall mean  
143 the following: (1) health care services rendered by an out-of-network provider for emergency  
144 medical conditions, including post-stabilization services resulting from an emergency medical  
145 condition; (2) non-emergency health care services rendered by an out-of-network provider at an  
146 in-network facility, including but not limited to: (i) services for emergency medicine,  
147 anesthesiology, pathology, radiology, or neonatology, or services rendered by assistant surgeons,  
148 hospitalists, and intensivists; (ii) health care services rendered by an out-of-network provider  
149 without the insured’s advanced knowledge, pursuant to the requirements set forth in subsections  
150 (b) through (e) of section 228 of chapter 111; (iii) health care services provided by an out-of-  
151 network provider if there is no in-network provider who can furnish such health care service at  
152 such facility; (iv) health care services rendered by an out-of-network provider, including an out-  
153 of-network laboratory, radiologist, or pathologist, where the health care services were referred,  
154 or an insured’s specimen was sent, by a participating provider to an out-of-network provider; or  
155 (v) unforeseen health care services that arise at the time health care services are rendered that  
156 must necessarily be rendered by an out-of-network provider; and (3) health care services  
157 delivered by an ambulance service provider licensed by the department of public health pursuant  
158 to section 6 of chapter 111C.

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

165 (c) A carrier shall reimburse an out-of-network provider who renders an unforeseen out-  
166 of-network service to an insured at the carrier's median contracted rate for that service in the  
167 geographic region in the relevant market. Such payment shall constitute payment in full to the  
168 out-of-network provider and the out-of-network provider shall not bill the insured for any  
169 amount except for any in-network cost sharing amount owed for such service.

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

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

183 (f) Nothing in this section shall require a carrier to pay for nonemergency services  
184 delivered to an insured if the insured had a reasonable opportunity to choose to have the service  
185 performed by a network provider participating in the insured's health benefit plan. Evidence that

186 an insured had a reasonable opportunity to choose to have the service performed by a  
187 participating provider may include, but is not limited to, a consent waiver signed by the insured.

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