JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY

Bill No: H1126

Title: AN ACT TO STREAMLINE PATIENT DISCLOSURE REQUIREMENTS

Sponsor: Rep. Michael S. Day (*Stoneham)*

Hearing Date: July 15, 2025

Reporting Deadline: August 13, 2025

Prior History: 2023-24 (H970): Ordered to a House Study

Similar Matters: S762 (Friedman – Identical)

CURRENT LAW:
M.G.L. c. 111 Public Health § 228 Allowed amount; advance disclosure of allowed amount or charge for admission, procedure or service; referrals; nonparticipation in plan; penalties

M.G.L. c. 176O Health Insurance Consumer Protections § 1 Definitions
"Emergency medical condition", a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section *1867(e)(1)(B) of the Social Security Act, 42 U. S.C. section 1395dd(e)(1)(B).*

M.G.L. c. 176O Health Insurance Consumer Protections § 23 Disclosure by carrier upon request for network status of health care provider and estimated or maximum allowed amount or charge for a proposed admission, procedure or service and amount insured responsible to pay; establishment of toll-free telephone number and website
All carriers shall establish a toll-free telephone number and website that enables consumers to request and obtain from the carrier, in real time, the network status of an identified health care provider, the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured, will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits; provided, that the insured shall not be required to pay more than the disclosed amounts for the covered health care benefits that were actually provided; provided, however, that nothing in this section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's evidence of coverage for unforeseen services that arise out of the proposed admission, procedure or service; and provided further, that the carrier shall alert the insured that these are

estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

Chapter 260 of the Acts of 2020, An Act promoting a resilient health care system that puts patients first § 25
Mandates that healthcare providers disclose certain information to patients regarding their network status and potential costs before scheduling or providing non-emergency services. This includes whether the provider is in-network and, if not, the potential costs associated with out-of-network care.
(f) The commissioner shall implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers; provided, however, that the penalty for non-compliance shall not exceed $2,500 in each instance. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant to this subsection shall be liable for penalties as provided in this subsection.

Chapter 260 of the Acts of 2020, An Act promoting a resilient health care system that puts patients first § 75 Subsection (f) of section 228 of chapter 111 of the General Laws shall take effect on January 1, 2022.

Chapter 22 of the Acts of 2022, An Act making appropriations for the fiscal year 2022 to provide for supplementing certain existing appropriations and for certain other activities and projects § 3
Section 75 of chapter 260 of the acts of 2020 is hereby amended by striking out the words "January 1" and inserting in place thereof the following words: - July 31.

Chapter 107 of the Acts of 2022, An Act relative to extending certain state of emergency accommodations § 2
Section 75 of chapter 260 of the acts of 2020, as amended by section 3 of chapter 22 of the acts of 2022, is hereby further amended by striking out the words "July 31, 2022" and inserting in place thereof the following words: - January 1, 2025.

Chapter 248 of the Acts of 2024, An Act making appropriations for the fiscal year 2024 to provide for supplementing certain existing appropriations and for certain other activities and projects § 31
Section 75 of chapter 260 of the acts of 2020 is hereby amended by striking out the figure "2025", inserted by section 2 of chapter 107 of the acts of 2022, and inserting in place thereof the following figure: - 2027.

42 USC section 300gg-136 Provision of information upon request and for scheduled appointments
Each health care provider and health care facility will, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and
(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to—
(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and
(B) in the case the individual is not described in subparagraph (A) and not enrolled in a federal health care program, the individual.

Public Health Service Act section 2799B–6, also known as 42 USC 300gg-136, requires providers and facilities to furnish individuals with a good faith estimate (GFE) of the expected cost of medical services. This provision was added by the Consolidated Appropriations Act of 2021 as part of the *No Surprises Act*. The GFE must be provided upon request or upon scheduling, and it applies to individuals who are not enrolled in a health plan or coverage, or who are not seeking to file a claim with their coverage.

SUMMARY:
The proposed legislation states that if a patient or prospective patient schedules a series of admissions, procedures or services as part of a continued course of treatment, a health care provider would not be required to make the disclosure as to whether they participate in the patient's health benefit plan for subsequent admissions, procedures or treatments, as long as the provider made and documented the initial disclosure.

Under current state law and upon a patient's request, at the time of scheduling an admission, procedure or service, a health care provider will, within 2 days of the request, notify a patient the allowed amount and facility fees. If the provider is unable to quote a specific amount, they will disclose the maximum amount allowed for the admission, procedure or service and the amount of any anticipated facility fees.

Whereas this proposed legislation changes the law to require a participating provider to provide the patient's health insurance carrier with a good faith estimate of the expected billing and diagnostic codes for any admission, procedure or service. A participating health care provider would inform the patient or prospective patient that they may obtain additional information about any applicable out-of-pocket costs pursuant to *section 23 of chapter 176O* (information on carrier's website and via carrier's toll-free number). A health insurance carrier would then provide the patient with the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service in the form of a notification in clear and understandable language as required under the *Public Health Service Act section 2799B–6, as added by Section 112 of Title I of Division BB of the Consolidated Appropriations Act of 2021 as codified at 42 USC section 300gg-136*. The health insurance carrier would provide the patient with the estimated amount the insured will be responsible to pay for a proposed admission,

procedure or service within 3 business days if their admission, procedure or service is scheduled at least 10 days in advance, or within 1 business day if there are fewer than 10 days before the admission, procedure or service.

Under current state law, if the health care provider is not participating in the patient's or prospective patient's health benefit plan, the health care provider will, at the time of scheduling the admission, procedure or service: (i) provide the charge and the amount of any facility fees for the admission, procedure or service; (ii) inform the patient or prospective patient that the patient or prospective patient will be responsible for the amount of the charge and the amount of any facility fees for the admission, procedure or service not covered through the patient's health benefit plan; and (iii) inform the patient or prospective patient that the patient or prospective patient may be able to obtain the admission, procedure or service at a lower cost from a health care provider who participates in the patient's or prospective patient's health benefit plan.

Whereas under the proposed legislation, if the health care provider is not participating in the patient's or prospective patient's health benefit plan, or the patient is uninsured or otherwise not using their health benefit plan, the health care provider would provide patients with relevant cost information regarding the scheduled admission, procedure or service, including a good faith estimate of the charge amount and the amount of any facility fees for the admission, procedure or service. The provider would inform the patient or prospective patient that the patient or prospective patient will be responsible for the amount of the charge and the amount of any facility fees for the admission, procedure or service not covered through the patient's health benefit plan and will inform the patient or prospective patient that the patient or prospective patient may be able to obtain the admission, procedure or service at a lower cost from a health care provider who participates in the patient's or prospective patient's health benefit plan.

A good faith estimate would be provided to a patient within 1 business day after the appointment was scheduled if the appointment was scheduled at least 3 business days before the admission, procedure or service and within 3 business days of scheduling if the appointment is made at least 10 business days in advance.

The proposed legislation would allow provider compliance through compliance with federal provider notice requirements (*Public Health Service Act section 2799B–6, as added by Section 112 of Title I of Division BB of the Consolidated Appropriations Act of 2021, as implemented under 45 CFR section 149.610(c)).*

Currently the insurance commissioner is required to implement and enforce the provisions of the law, including imposing penalties for non-compliance consistent with the department's authority to regulate health care providers. The non-compliance penalty is capped at $2,500 per instance.

This proposed legislation would allow the insurance commissioner to implement and impose non-compliance penalties rather than requiring the commissioner to do so as is the case under current state law. Additionally, the proposed legislation directs that the division of insurance will impose no penalty if a provider has been subject to a penalty by the Centers for Medicare and Medicaid Services for the same violation.

The proposed legislation would take effect, for participating health care providers, upon the effective date of regulations implementing *42 USC section 300gg-136.*