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

Bill No: H1144

Title: AN ACT TO PROTECT CONSUMERS FROM SURPRISE BILLING

Sponsor: Rep. Paul J. Donato (*Medford*)

Hearing Date: July 15, 2025

Reporting Deadline: August 13, 2025

Prior History:
2023-24 (H997): Reported favorably; Referred to Health Care Financing; Ordered to a House Study
2021-22 (H1066): Reported favorably; Referred to Health Care Financing; Ordered to a House Study
2019-20 (H957): Ordered to a House Study

Similar Matters: None

CURRENT LAW:
M.G.L. c. 93A Regulation of business practices for consumers protection

M.G.L. c. 111 Public Health § 228 Advance disclosure of allowed amount or charge for admission, procedure or service; referrals; nonparticipation in plan; penalties
A health care provider will determine if it participates in a patient's health benefit plan prior to a patient's admission, procedure or service for conditions that are not emergency medical conditions.

If the health care provider does not participate in the patient's health benefit plan and an admission, procedure or service was scheduled more than 7 days in advance, the provider will notify the patient of that fact verbally and in writing not less than 7 days prior to the admission, procedure or service.

If a health care provider does not participate in a patient's health benefit plan and the admission, procedure or service was scheduled less than 7 days in advance, the provider will notify the patient of that fact verbally not less than 2 days prior, or as soon as is practicable before the scheduled admission, procedure or service, with written notice to be provided upon the patient's arrival for 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, the provider will 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.

M.G.L. c. 175H False Health Care Claims § 5 Investigation and proceedings by attorney general
Section 5. The attorney general may investigate an alleged violation of this chapter and may commence a proceeding.

M.G.L. c. 175H False Health Care Claims § 6 Liability for false claims; civil proceedings
A person who receives a health care benefit or payment from a health care corporation or health care insurer 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, shall be liable to the health care corporation or health care insurer 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 may bring a civil action under this chapter in the superior court department of the trial court.

Emergency Care
M.G.L. c. 176G Health Maintenance Organizations (HMOs)§ 5(f) Emergency services provided to members for emergency medical conditions
An HMO will pay reasonable charges for the cost of emergency medical services by a provider not normally affiliated with the HMO when a member requires services for an emergency medical condition.

M.G.L. c. 176I Preferred Provider Arrangements (PPOs)§ 3(b) Health benefit plans; minimum requirements; 211 CMR 51.05(2)(b)
If a patient receives emergency care and cannot reasonably reach a preferred provider, the insurer must pay for care related to the emergency at the same level as if the patient had been treated by a preferred provider.

Out-of-Network Care at an In-Network Facility
M.G.L. c. 176O Health Insurance Consumer Protections § 6(a)(4)(ii) Evidence of coverage to be delivered to covered adults by health, dental and vision care providers; contents
Whenever a location is part of a carrier's network the carrier will cover medically necessary covered benefits delivered at that location and an insured will not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider. This must be explained in an insured's Evidence of Coverage.

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.

SUMMARY:
This bill addresses billing issues, specifically facilities fees and surprise billing. It increases non-compliance fees and notice requirements. The bill creates a cause of action under *M.G.L. c. 93A*, the Massachusetts Consumer Protection Act.

SECTION 1. The bill adds a new section to *M.G.L. c. 111 Public Health, Section 51M. (a)* The following definitions are included in this section:

“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.

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

(b) Facility fees will be allowed only in certain circumstances, for services provided on a hospital’s campus; services provided at a facility that includes a licensed hospital emergency department; or emergency services provided at a licensed satellite emergency facility.

(c) A health care provider will not charge, bill, or collect a facility fee for a service that the Health Policy Commission identifies as one that can reliably be safely and effectively provided in a setting other than a hospital.

(d) The department of public health will promulgate regulations necessary to implement this section and will impose non-compliance penalties. Any health care provider that violates any provision of this section or the associated rules and regulations will be fined up to $1,000 per occurrence.

This bill adds a second new section to *M.G.L. c. 111 Public Health, Section 51N.*
(a) Providers charging facility fees will provide any patient receiving such services with written notice that the fees will be charged and that they may be billed separately from other services.

(b) If a health care provider is required to provide a patient with notice and a patient’s appointment is scheduled to occur not less than 10 days after the appointment is made, the health care provider will 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 will 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 will provide an explanation of the fee to the patient within a reasonable period. The explanation of the fee will 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 will be provided to the patient’s representative within a reasonable period.

(c) A facility at which facility fees for services are charged, billed, or collected will 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 will 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 will be prominently displayed in locations accessible to and visible by patients, including in patient waiting areas.

(e) (1) If a location changes status from a location where facility fees are not collected, to one where such fees are collected, the provider that owns or operates the facility will provide written notice to all patients who received services at the location during the previous calendar year within 30 days of the change. The notice will be filed with the department of public health. Facility fees will be waived for 30 days after the notice is provided. Violaters will be fined up to $1,000 per occurrence.

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

(3) Provided or required notices will be filed with the department of public health within 30 days.

(f) The department of public health 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 will 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 will be an unfair trade practice under chapter 93A.

SECTION 2. This section amends *M.G.L. c. 111 Public Health § 228 (e) Allowed amount; advance disclosure of allowed amount or charge for admission, procedure or service; referrals; nonparticipation in plan; penalties,* to include unforeseen out-of-network services.

If a health care provider that does not participate in the patient's health benefit plan fails to provide the required notifications, or if the provider is rendering unforeseen out-of-network services, the provider will 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.

SECTION 3. This section amends *M.G.L. c. 175H False Health Care Claims § 1 Definitions,* adding definitions for "Impermissible facility fee" and "Surprise bill".

SECTION 4. This section amends *M.G.L. c. 175H False Health Care Claims,* to give the attorney general authority to enforce this chapter. Anyone who knowingly submits a fraudulent claim regarding an impermissible facility fee will be liable to a health care corporation or insurer or other person or entity for the full amount of the benefit or payment, and for reasonable attorneys' fees. A health care corporation or insurer or other injured party or entity may bring a civil action under this chapter. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity will be prohibited from balance billing an insured.

SECTION 5. This section amends *M.G.L. c 176J Small Group Health Insurance*
Carriers will reimburse evaluation and management services delivered by an off-campus hospital outpatient department, clinic, ambulatory surgical center, or stand-alone emergency department, and ambulatory services commonly provided in office-based settings, including but not limited to laboratory tests, imaging, and diagnostic services, and clinician-administered drugs that the health policy commission identifies as equivalent to the non-facility rate in the Medicare physician fee schedule that applies to physician offices.

SECTION 6. This section amends *M.G.L. c. 176O Health Insurance Consumer Protections*
It adds a section relative to "unforeseen out-of-network service". An insured will 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. A carrier will reimburse an out-of-network provider who renders an unforeseen out-of-network service at the carrier's median contracted rate. Such payment will be considered payment in full and balance billing an insured will be prohibited.