HOUSE DOCKET, NO. 2764   FILED ON: 1/17/2019

HOUSE . . . . No. 932

The Commonwealth of Massachusetts

PRESENTED BY:

Gerard J. Cassidy

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:
Gerard J. Cassidy	*9th Plymouth*
Michael D. Brady	*Second Plymouth and Bristol*
Michelle M. DuBois	*10th Plymouth*

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HOUSE . . . . No. 932

By Mr. Cassidy of Brockton, a petition (accompanied by bill, House, No. 932) of Gerard J. Cassidy, Michael D. Brady and Michelle M. DuBois relative to out of network healthcare insurance billing . Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

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:

1 The General Laws are hereby amended by inserting after chapter 176O the following
2 chapter:

3 CHAPTER 176O1/2.

4 Section 1. Definitions

5 As used in this chapter, the following words shall, unless the context clearly requires
6 otherwise, have the following meanings:-

7 "Clinician", a physician licensed under section 2 of chapter 112, or advance practice
8 clinician, including but not limited to a physician assistant licensed pursuant to section 9F of
9 chapter 112, and advanced practice nurses, including but not limited to certified nurse
10 practitioners, certified registered nurse anesthetists, certified nurse midwives, and psychiatric
11 clinical nurse specialists licensed pursuant to section 80B of chapter 112.

12 “Clinician’s Allowed Amount”, a Clinician’s Usual and Customary Amount after the
13 discount applied under a Clinician’s contractual arrangement with an Insurance Carrier, if any, or
14 the amount of the allowed benefit if the Clinician is Out of Network. The Clinician’s Allowed
15 Amount constitutes the Clinician’s contractually adjusted total expected payment for a
16 professional service if the Clinician has a contractual arrangement with an Insurance Carrier.

17 “Clinicians’ Usual and Customary Charge”, the charges routinely billed by Clinicians’
18 for their professional services regardless of payer involved and before any discounts that are
19 applied pursuant to charity or indigent patient charge policies or Insurance Carrier contracting
20 discounts. Absent other considerations, the Usual and Customary Charge constitutes the
21 Clinician’s total expected payment for a service.

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

30 “In Network Services”, professional services provided to an Insured by Clinicians who
31 have contracted with the Insurance Carrier that insures the Insured.

32 “Insurance Carrier”, an insurer licensed or otherwise authorized to transact accident or
33 health insurance under chapter 175; a nonprofit hospital service corporation organized under

34 chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health
35 maintenance organization organized under chapter 176G; and an organization entering into a
36 preferred provider arrangement under chapter 176I, but not including an employer purchasing
37 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or
38 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not
39 include any entity to the extent it offers a policy, certificate or contract that is not a health benefit
40 plan, as defined in section 1 of chapter 176J.

41 "Insurance Carrier Insured Allowable", the benefit amount that the Carrier assigns for the
42 service rendered by a Clinician who has not entered into a contractual arrangement with the
43 Insurance Carrier that insures the Insured.

44 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a
45 carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under
46 review, or any other individual whose care may be subject to review by a utilization review
47 program or entity as described under other provisions of chapter 176O.

48 "Insured Balance Bill", the amount of the Clinician's Usual and Customary Charge that
49 remains after the Insurance Carrier determines the Insurance Carrier Out of Network benefit and
50 Insured Cost Sharing amount.

51 "Insured Co-Insurance", the portion of the Clinician's charge for professional services
52 that the Insured is financially responsible for paying directly to the Clinician who rendered the
53 professional services pursuant to the terms of the contractual arrangement between the Insured
54 and the Insurance Carrier.

55 “Insured Co-Payment”, the amount that is the Insured’s responsibility for professional
56 services received from a Clinician, as dictated by the terms of the contractual arrangement
57 between the Insured and the Insurance Carrier. A co-pay amount may be stated as a percentage
58 or as a flat rate for services.

59 “Insured Cost Sharing”, the combination of the Insured Deductible, Co-Insurance and
60 Co-Payment or those amounts that are the responsibility of the Insured for a Clinician’s
61 professional services. Insured Cost Sharing for an Unavoidable Out of Network Services bill
62 shall be limited to the amount that the Insured would have paid the Clinician for In-Network
63 services.

64 “Insured Deductible”, the Insured’s financial responsibility for the Clinician’s charges
65 that is applied to the Clinician’s Usual and Customary charges before applying either co-
66 insurance or co-payments.

67 “Mediation”, the process to mediate disputes between an Insurance Carrier and Clinician
68 that is conducted outside of a formal court process; provided, however, that mediation shall only
69 be legally binding if the parties have mutually agreed to it in writing.

70 “Medicare Physician Fee Schedule”, the fee schedule modified and published annually by
71 the Centers for Medicare and Medicaid for professional services.

72 “Minimum Benefit Standard”, the greatest of the following amounts: (i) the amount the
73 insured's health care plan would pay for such services if rendered by an in-network health care
74 provider; (ii) the usual and customary rate for such services, or (iii) the amount Medicare would
75 reimburse for such services. As used in this subparagraph, "usual and customary rate" means the
76 eightieth percentile of all charges for the particular health care service performed by a health care

77 provider in the same or similar specialty and provided in the same geographical area, as reported
78 in an independent benchmarking database maintained by a nonprofit organization specified by
79 the Commissioner of the Division of Insurance. Such organization shall not be affiliated with any
80 health carrier.

81 “Opt Out Services”, Out of Network Clinician Services in an Inpatient Hospital or
82 Outpatient Hospital where the Insured voluntarily selects in writing to receive services from an
83 Out of Network Clinician and is offered an estimate of Out of Network Charges and consents in
84 writing to be treated by an Out of Network Clinician and be financially responsible for Out of
85 Network Services. Opt Out Services shall not include emergency department services and any
86 related on call services provided to an Insured whose care begins in an emergency department.

87 “Out of Network Services”, a Clinician’s professional services provided to an Insured
88 where the Clinician is not contracted with both the Insured’s Insurance Carrier and the Insured’s
89 health insurance product/plan offered by the Insured’s Insurance Carrier.

90 "Self-Funded Health Benefits Plan" or "Self-Funded Plan", a self-insured health benefits
91 plan governed by the provisions of the federal "Employee Retirement Income Security Act of
92 1974," 29 U.S.C. s.1001 et seq.

93 "Unavoidable Out of Network bill", a bill for Out of Network Services received by an
94 insured for services rendered by a Clinician, where such Out of Network Services were rendered
95 by such out-of-network Clinician at an in-network facility, or during a service or procedure
96 previously approved or authorized by the health carrier and the insured did not have the ability to
97 control to select such services from an in-network Clinician. A bill for Out of Network Services
98 received by an Insured to screen for, evaluate, diagnose and/or treat an emergency medical

99 condition by an out-of-network Clinician at an in-network facility shall be deemed an
100 “Unavoidable Out of Network bill”. "Unavoidable Out of Network bill" does not include a bill
101 for non-emergency services received by an insured when the insured voluntarily selects in
102 writing an out of network Clinician prior to the provision of the service or when the insured has
103 the ability and control to select an in-network Clinician prior to the provision of the service but
104 declines to exercise that option.

105 Section 2. The Minimum Benefit Standard for Insured Services

106 (a) If Out of Network Services are provided to an Insured by a Clinician resulting in
107 an Unavoidable Out of Network bill, such Clinician shall bill the Insured’s Insurance Carrier
108 directly and the Insurance Carrier shall pay the Clinician for the professional services as coded
109 and billed by the Clinician;

110 (b) Insurance Carriers shall make payment directly to the Clinician for an
111 Unavoidable Out of Network bill for covered services within 30 calendar days of the submission
112 of claim by the Clinician;

113 (c) The Insurance Carrier shall adjudicate the Insured’s claim for Out of Network
114 Services that result in an Unavoidable Out of Network bill at the Insured’s In-Network benefits
115 levels and the Insured’s Cost Sharing for Out of Network Services shall be limited to amount that
116 the Insured would have paid the Clinician for In-Network services;

117 (d) Insured Deductible for Out of Network services that result in an Unavoidable Out
118 of Network bill shall be applied by the Insurance Carrier to Insured’s Deductible for in-network
119 services;

120 (e) Insurance Carriers shall make payment directly to the clinician providing Out of
121 Network Services that result in an Unavoidable Out of Network bill at an amount not less than
122 the Minimum Benefit Standard.

123 (f) Clinicians shall be prohibited from submitting a claim or charges for an Insured
124 Balance Bill for Unavoidable Out of Network services to the Insured, provided that the
125 Minimum Benefit Standard has been paid to the Clinician by the Insurance Carrier and provided
126 that the Insured has not Opted Out of these protections for non-emergency services pursuant to
127 section 3 of this chapter;

128 (g) In the case of services provided to a member of a Self-Funded Plan that does not
129 elect to be subject to the provisions of this section, the Clinician shall be permitted to bill the
130 covered person in excess of the applicable deductible, copayment, or coinsurance amounts.

131 Section 3. Opt Out Services

132 (a) A Clinician shall be prohibited from Insured Balance Billing for Unavoidable Out
133 of Network services, except in the case of Opt Out Services.

134 (b) If there is a dispute regarding the Involuntary Out of Network service payment or
135 charges the Clinician may institute mediation pursuant to the provisions of this chapter.

136 Section 4. Mediation

137 (a) A Clinician may initiate the mediation process by providing written notice of the
138 dispute to the Insurance Carrier and the entity that will determine the mediation process.

139 (b) Mediation resolution shall be within 30 days of the date the mediation request is
140 received by the Insurance Carrier, and Division of Insurance or its designee shall determine the
141 mediation process.

142 (c) A Clinician shall be permitted to bundle similar claims or claims presenting
143 common issues of fact or law can be bundled together and adjudicated in one mediation process
144 to promote speedy dispute resolutions.

145 (d) The mediation official may select from either party's proposal but shall not create
146 his own reimbursement rate.

147 (e) The Medicare Physician Fee Schedule shall not be used as a reference point for
148 mediation process as it is a statutory and regulated fee schedule subject to budgetary and policy
149 limitations established by Congress and Center for Medicare and Medicaid Services.

150 Section 5. False or Misleading Statements in Insurance Carrier Information

151 An Insurance Carrier shall not state, communicate or include in written form false,
152 misleading or confusing information in their explanation of benefits to Insureds regarding
153 Clinician Usual and Customary Charges, Out of Network Balance Billing, or mediation disputes
154 between Clinicians and Insurance Carriers.

155 Section 6. Enforcement for non-compliance by Insurance Carriers or Clinicians

156 (a) A Clinician shall be prohibited from submitting a claim or charges in violation of
157 this chapter.

158 (b) A Clinician who engages in a pattern and practice of regularly sending or
159 communicating Out of Network Balance Bills to an Insured in violation of these provisions,

160 except for cases of excusable neglect, shall lose the right to file mediation demands under
161 provisions of this chapter.

162 (c) An Insurance Carrier that is in violation of this chapter is subject to sanctions,
163 penalties and other corrective actions by the Division of Insurance

164 Section 7. Disclosure

165 (a) An Insurance Carrier shall inform an Insured or the Insured's Clinician, as
166 applicable, at the time the Insured or the Insured's Clinician requests a prospective or concurrent
167 review: (1) the network status under the Insured's health benefit plan of the Clinician who will
168 be providing the health care service or course of treatment; and (2) an estimate of the amount the
169 Insurance Carrier will pay such Clinician for such service or treatment pursuant to the Minimum
170 Benefit Standard.

171 (b) At the time of scheduling an admission, procedure or service for an insured
172 patient or prospective patient, a health care provider shall: (i) determine the provider's own
173 network status relative to insured's insurance carrier and specific health benefit plan and disclose
174 in real time such network status to the insured.

175 (c) At the time of scheduling an admission, procedure or service for an insured
176 patient or prospective patient, a health care provider, upon request by a patient or prospective
177 patient, shall (i) notify the patient or prospective patient of their right to request and obtain from
178 the provider provide, based on information available to the provider at the time of the request,
179 additional information on the network status of any provider reasonably expected to render
180 services in the course of such admission, procedure or service that is necessary for the patient's
181 or prospective patient's use of a health benefit plan's toll-free number and website available

182 pursuant to section 23 of chapter 176O to obtain additional information about that provider's
183 network status under the patient's or prospective patient's health benefit plan and any applicable
184 out-of-pocket costs for services sought from such provider; (ii) provide, based on information
185 available to the provider at the time of the request, information on such admission, procedure or
186 service that is necessary for the patient's or prospective patient's use of a health benefit plan's
187 toll-free number and website available pursuant to section 23 of chapter 176O to identify the
188 allowed amount or charge of the admission, procedure or service, including the amount for any
189 facility fees required; (iii) notify the patient or prospective patient that in the event a health care
190 provider is unable to quote a specific allowed amount or charge in advance of the admission,
191 procedure or service due to the health care provider's inability to predict the specific treatment or
192 diagnostic code, the estimated maximum allowed amount or charge for a proposed admission,
193 procedure or service, including the amount for any facility fees required; and (iv) inform the
194 patient or prospective patient that the estimated costs and the actual amount the patient or
195 prospective patient may be responsible to pay may vary due to unforeseen services that arise out
196 of the proposed admission, procedure or service. This subsection shall not apply in cases of
197 emergency services provided to a patient.

198 (d) If a network provider schedules, orders or otherwise arranges for services related
199 to an insured's admission, procedure or service and such services are performed by another
200 health care provider, or if a network provider refers an insured to another health care provider for
201 an admission, procedure or service, then in addition to the actions required pursuant to
202 subsection

203 (b) the network provider shall, based on information available to the provider at that time:
204 (i) disclose to the insured if the provider to whom the patient is being referred is part of or
205 represented by the same provider organization registered pursuant to section 11 of chapter 6D;

206 (ii) disclose verbally or in writing to the insured sufficient information about such
207 provider for the patient to obtain information about that provider's network status under the
208 insured's health benefit plan and identify any applicable out-of-pocket costs for services sought
209 from such provider through the toll-free number and website of the insurance carrier available
210 pursuant to section 23 of chapter O; and (iii) notify verbally or in writing the insured that if the
211 health care provider is out-of-network under the patient's health insurance policy, that the
212 admission, service or procedure will likely be deemed out-of-network and that any out-of-
213 network applicable rates under such policy may apply. This subsection shall not apply in cases of
214 emergency services provided to a patient.

215 Section 8. Self-Funded Plans

216 (a) With respect to an entity providing or administering a Self-Funded Health
217 Benefits Plan and its plan members, this Chapter shall only apply if the plan elects to be subject
218 to the provisions of this Chapter. To elect to be subject to the provisions of this Chapter, the
219 self-funded plan shall provide notice, on an annual basis, to the Division of Insurance, on a form
220 and in a manner prescribed by the Division, attesting to the plan's participation and agreeing to
221 be bound by the provisions of this Chapter. The self-funded plan shall amend the employee
222 benefit plan, coverage policies, contracts and any other plan documents to reflect that the
223 benefits of this section shall apply to the plan's members.

224 (b) An Insurance Carrier, and any other entity providing or administering a Self-
225 Funded Health Benefits Plan that elects to be subject to this Chapter, shall issue a health
226 insurance identification card to the primary insured under a health benefits plan. In a form and
227 manner to be prescribed by the department, the card shall indicate whether the plan is insured or,
228 in the case of self-funded plans that elect to be subject to this Chapter, whether the plan is self-
229 funded and whether the plan elected to be subject to this act.