HOUSE DOCKET, NO. 2877 FILED ON: 1/20/2017

HOUSE . . . . . No. 2164

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 ban hospital facility fees and surprise billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Paul J. Donato	*35th Middlesex*

HOUSE DOCKET, NO. 2877 FILED ON: 1/20/2017

HOUSE . . . . . No. 2164

By Mr. Donato of Medford, a petition (accompanied by bill, House, No. 2164) of Paul J. Donato relative to health insurance consumer protections from billing for certain health care services, other than emergency services . Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act to ban hospital facility fees and 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 176O of the General Laws is hereby amended by adding at the end thereof the following section:

Section 28 : Surprise Bills

(a) Definitions. For the purposes of this section:

(1) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in : (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of

such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the social security act 42 U.S.C. § 1395dd.

(2) "Emergency services" means, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency Division of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient.

(3) "Insured" means a patient covered under a carrier's policy or contract.

(4) "Non-participating" means not having a contract with a health care plan to provide health care services to an insured.

(5) "Participating" means having a contract with a carrier to provide health care services to an insured.

(6) "Patient" means a person who receives health care services, including emergency services, in this state.

(7) " Non-participating provider rate" means with respect to payment to a non-participating provider under this section, 110 percent of the Medicare reimbursement rate or reasonable approximation thereof for those services as if they were rendered to a Medicare beneficiary not taking into consideration any beneficiary cost sharing. For services or supplies for which there is no Medicare reimbursement amount, the amount as determined by the

commissioner of the center for health information and analysis is to be consistent with Medicare payment policies at a 110 percent level and set in consultation with the commissioner of insurance.

(8) "Surprise bill" means a bill for health care services, other than emergency services, received by:

(A) an insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;

(B) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the carrier; or

(b) Emergency Services.

(1) Emergency services for an insured.

(A) When a carrier receives a bill for emergency services from a non-participating physician, the carrier shall pay the non-participating provider rate for the emergency services rendered by the non-participating physician, except for the insured's co-payment, coinsurance or

deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician.

(c) Hold Harmless And Assignment Of Benefits For Surprise Bills For Insureds.

When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a carrier, the non-participating physician shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

(d) Surprise Bills.

(1) Surprise bill received by an insured that assigns benefits.

(A) If an insured assigns benefits to a non-participating physician, the carrier shall pay the non-participating physician the non-participating provider rate for the health care services rendered, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician.

(e) Carrier Notification. Each carrier shall:

(1) Include in the insurance policy, certificate of coverage or handbook provided to covered persons a clear and comprehensive description of what constitutes a surprise bill, as defined in subsection (a) above;

(2) Inform a covered person or the covered person's health care professional, as applicable, at the time the covered person or the covered person's health care professional requests a prospective or concurrent review: (A) The network status under such covered person's

health benefit plan of the health care professional who will be providing the health care service or course of treatment; (B) an estimate of the amount the carrier will reimburse such health care professional for such service or treatment; and (C) how such amount compares to the usual, customary and reasonable charge, as determined by the Centers for Medicare and Medicaid Services, for such service or treatment;

(3) Prominently post on its Internet web site the description required under subparagraph (A) above.

SECTION 2. Chapter 111 of the General Laws is hereby amended by adding a new Section 53J :

Section 53J Surprise Bills. Non-Emergency Out-Of-Network Services.

(1) At the time a participating hospital or health system schedules a procedure or seeks prior authorization from a health insurer for the provision of non-emergency services to a covered person, the hospital or health system shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain hospital or health system -based providers may be called upon to render care to the covered person during the course of treatment;

(b) That those hospital or health system -based providers may not have contracts with the covered person’s health insurer and are therefore considered to be out-of-network;

(c) That the service(s) therefore will be provided on an out-of-network basis;

FACILITY FEES

Adding a new Section 53I of Chapter 111:

Section 53I, Facility Fees

(a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) 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 two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(6) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

(7) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

(8) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) On and after January 1, 2018, no hospital, health system or hospital-based facility shall collect a facility fee for:

(1) Outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus; or

(2) Outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate.

Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2017, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect

reimbursement from the health insurer for such facility fees until the date of expiration of such contract.

A violation of this subsection shall be considered an unfair trade practice pursuant to Chapter 93A.