

HOUSE No. 997

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>1/19/2023</i>

HOUSE No. 997

By Representative Donato of Medford, a petition (accompanied by bill, House, No. 997) of Paul J. Donato relative to non-contracted and non-emergency healthcare billing. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 1066 OF 2021-2022.]

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Third General Court
(2023-2024)**

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 51K the following 2 sections:-

3 Section 51L. (a) As used in this section and section 51M, 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 may 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 51M. (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 51L, and
58 the health care provider that owns or operates the location elects to charge, bill, or collect facility
59 fees, the health care provider shall provide written notice to all patients who received services at
60 the location during the previous calendar year not later than 30 days after the change of status.
61 The notice shall state that: (i) the location is now owned or operated by a hospital; (ii) certain
62 health care services delivered at the facility may result in separate facility and professional bills
63 for services; and (iii) patients seeking care at the facility may incur higher financial liability at
64 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,

86 procedure or service was scheduled less than 7 days in advance of the admission,
87 procedure or service, such provider shall notify the patient verbally of that fact not less than 2
88 days before the scheduled admission, procedure or service or as soon as is practicable before the
89 scheduled admission, procedure or service, with written notice of that fact to be provided upon
90 the patient's arrival at the scheduled admission, procedure or service. If a health care provider
91 that does not participate in the patient's health benefit plan fails to provide the required
92 notifications under this subsection, or if the provider is rendering unforeseen out-of-network
93 services, as defined in subsection (a) of section 30 of chapter 176O, the provider shall not bill the
94 insured except for any applicable copayment, coinsurance or deductible that would be payable if

95 the insured received the service from a participating health care provider under the terms of the
96 insured’s health benefit plan. Nothing in this subsection shall relieve a health care provider from
97 the requirements under subsections (b) to (d), inclusive.

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

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

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

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

130 reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care
131 corporation or health care insurer or other injured person or entity may bring a civil action under
132 this chapter in the superior court department of the trial court.

133 SECTION 5. Chapter 176O of the General Laws is hereby amended by adding the
134 following section:-

135 Section 30. (a) As used in this section, "unforeseen out-of-network service" shall mean
136 the following: (1) health care services rendered by an out-of-network provider for emergency
137 medical conditions, including post-stabilization services resulting from an emergency medical

138 condition; (2) non-emergency health care services rendered by an out-of-network provider at an
139 in-network facility, including but not limited to: (i) services for emergency medicine,
140 anesthesiology, pathology, radiology, or neonatology, or services rendered by assistant surgeons,
141 hospitalists, and intensivists; (ii) health care services rendered by an out-of-network provider
142 without the insured's advanced knowledge, pursuant to the requirements set forth in subsections
143 (b) through (e) of section 228 of chapter 111; (iii) health care services provided by an out-of-
144 network provider if there is no in-network provider who can furnish such health care service at
145 such facility; (iv) health care services rendered by an out-of-network provider, including an out-
146 of-network laboratory, radiologist, or pathologist, where the health care services were referred,
147 or an insured's specimen was sent, by a participating provider to an out-of-network provider; or
148 (v) unforeseen health care services that arise at the time health care services are rendered that
149 must necessarily be rendered by an out-of-network provider; and (3) health care services
150 delivered by an ambulance service provider licensed by the department of public health pursuant
151 to section 6 of chapter 111C.

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

158 (c) A carrier shall reimburse an out-of-network provider who renders an unforeseen out-
159 of-network service to an insured at the carrier's median contracted rate for that service in the
160 geographic region in the relevant market. Such payment shall constitute payment in full to the

161 out-of-network provider and the out-of-network provider shall not bill the insured for any
162 amount except for any in-network cost sharing amount owed for such service.

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

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

176 (f) Nothing in this section shall require a carrier to pay for nonemergency services
177 delivered to an insured if the insured had a reasonable opportunity to choose to have the service
178 performed by a network provider participating in the insured's health benefit plan. Evidence that
179 an insured had a reasonable opportunity to choose to have the service performed by a
180 participating provider may include, but not be limited to, a consent waiver signed by the insured.

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