SENATE DOCKET, NO. 1602 FILED ON: 1/18/2019

SENATE . . . . . No. 659

The Commonwealth of Massachusetts

PRESENTED BY:

James T. Welch

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 access to invaluable, economical, and necessary treatments.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
James T. Welch	*Hampden*	
José F. Tosado	*9th Hampden*	*1/31/2019*
James K. Hawkins	*2nd Bristol*	*2/6/2019*

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SENATE . . . . . No. 659

By Mr. Welch, a petition (accompanied by bill, Senate, No. 659) of James T. Welch, José F. Tosado and James K. Hawkins for legislation to protect access to invaluable, economical, and necessary treatments. Financial Services.

The Commonwealth of Massachusetts

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

An Act to protect access to invaluable, economical, and necessary treatments.

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 6D of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following subsection:-

Section 16A. (a) The commission shall, upon consideration of advice or any other pertinent evidence, recommend the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter 176O. The noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services shall be in effect for a term of 5 years and shall apply to payments under clauses (ii) and (iv) of section 30 of said chapter 176O.

(b) In recommending rates, the commission shall consider: (i) the impact of each rate on the growth of total health care expenditures; (ii) the impact of each rate on in-network participation by health care providers; and (iii) whether each rate is easily understandable and administrable by health care providers and carriers. The commission shall not issue its

recommendations for the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services without the approval of the board established under subsection (b) of section 2.

(c) If the board approves the recommendations pursuant to subsection (b), the commission shall submit the recommendations to the division of insurance. The division may, not later than 30 days after the proposal has been submitted, hold a public hearing on the proposal. The division shall issue any findings within 20 days after the public hearing and shall make public those findings and any proposed regulation to implement those findings with respect to the recommendations of the commission. If the division does not issue final regulations with respect to the recommendations within 65 days after the commission submits the recommendations to division, the recommendations shall be adopted by the division as the noncontracted commercial rate for emergency services and noncontracted commercial rate for nonemergency services in effect for the applicable 5-year term.

(d) Prior to recommending the rates, the commission shall hold a public hearing. The hearing shall examine current rates paid for in- and out-of-network services and the impact of those rates on the operation of the health care delivery system and determine, based on the testimony, information and data, an appropriate noncontracted commercial rate for emergency services and noncontracted commercial rate for nonemergency services consistent with subsection (b). The commission shall provide public notice of the hearing not less than 45 days before the date of the hearing, including notice to the division of insurance. The division may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and other interested parties as the commission may determine. Any interested party may testify at the hearing.

(e) The commission shall conduct a review of established rates in the fourth year of the rates' operation. The commission shall further hold a public hearing under subsection (d) in said fourth year and recommend rates consistent with this section to be effective for the next 5-year term.

SECTION 2 . Section 10 of chapter 12C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof the following 2 subsections:-

(e) The center, in consultation with the executive office of health and human services, shall develop a process for reporting health care prices and related information from providers for use by consumers, employers and other stakeholders. The center shall develop and periodically update a list of the most common procedures and services and a list of the most common behavioral health services, including outpatient and diversionary mental health and substance use disorder services, based on data collected pursuant to this section and sections 8 and 9. The center shall require private and public health care payers to submit the payment rates for procedures and services and other information necessary for the center to determine the rate for every provider with which the payer has contracted or has a compensation arrangement. The center shall make the prices and related information publicly available on the consumer health information website required by section 20. The center shall keep confidential all nonpublic data obtained pursuant to this subsection and shall not disclose such data to any person without the consent of the provider or payer that produced the data; provided, however, that the center may disclose such data in an aggregated format. The center shall promulgate regulations necessary to implement this subsection.

(f) Except as specifically provided otherwise by the center or pursuant to this chapter, insurer data collected by the center pursuant to this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

SECTION 3 . Said chapter 12C is hereby further amended by striking out section 15, as so appearing, and inserting in place thereof the following section:-

Section 15. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Adverse event", harm to a patient resulting from a medical intervention and not the underlying condition of the patient.

"Agency", any agency of the executive branch of government in the commonwealth, including but not limited to any constitutional or other office, executive office, department, division, bureau, board, commission or committee thereof; or any authority created by the general court to serve a public purpose with either statewide or local jurisdiction.

"Board", the patient safety and medical errors reduction board.

"Healthcare-associated infection", an infection that a patient acquires during the course of receiving treatment for another condition within a healthcare setting.

"Lehman center", the Betsy Lehman center for patient safety and medical error reduction.

"Incident", an incident that, if left undetected or uncorrected, might have resulted in an adverse event.

"Medical error", the failure of medical management of a planned action to be completed as intended or the use of a wrong plan to achieve an outcome.

"Patient safety", freedom from accidental injury.

"Patient safety information", data and information related to patient safety, including adverse events, incidents, medical errors or healthcare-associated infections, that are collected or maintained by agencies.

(b) There shall be established within the center the Betsy Lehman center for patient safety and medical error reduction. The Lehman center shall serve as a clearinghouse for the development, evaluation and dissemination, including, but not limited to, the sponsorship of training and education programs, of best practices for patient safety and medical error reduction. The Lehman center shall: (i) coordinate the efforts of state agencies engaged in the regulation, contracting or delivery of health care and those individuals or institutions licensed by the commonwealth to provide health care to meet their responsibilities for patient safety and medical error reduction; (ii) assist such entities to work as part of a total system of patient safety; and (iii) develop appropriate mechanisms for consumers to be included in a statewide program for improving patient safety. The Lehman center shall coordinate state participation in any appropriate state or federal reports or data collection efforts relative to patient safety and medical error reduction. The Lehman center shall analyze available data, research and reports for information that would improve education and training programs that promote patient safety.

(c) Within the Lehman center, there shall be established a patient safety and medical errors reduction board. The board shall consist of the secretary of health and human services, the executive director of the center, the director of consumer affairs and business regulations and the

attorney general. The board shall appoint, in consultation with the advisory committee, the director of the Lehman center by a unanimous vote and the director shall, under the general supervision of the board, have general oversight of the operation of the Lehman center. The director may appoint or retain and remove expert, clerical or other assistants as the work of the Lehman center may require. The coalition for the prevention of medical errors shall serve as the advisory committee to the board. The advisory committee shall, at the request of the director, provide advice and counsel as it considers appropriate including, but not limited to, serving as a resource for studies and projects undertaken or sponsored by the Lehman center. The advisory committee may also review and comment on regulations and standards proposed or promulgated by the Lehman center, but the review and comment shall be advisory in nature and shall not be considered binding on the Lehman center.

(d) The Lehman center shall develop and administer a patient safety and medical error reduction education and research program to assist health care professionals, health care facilities and agencies and the general public regarding issues related to the causes and consequences of medical error and practices and procedures to promote the highest standard for patient safety in the commonwealth. The Lehman center shall annually report to the governor and the general court relative to the feasibility of developing standards for patient safety and medical error reduction programs for any state department, agency, commission or board to reduce medical errors, and the statutory responsibilities of the commonwealth, for the protection of patients and consumers of health care together with recommendations to improve coordination and effectiveness of the programs and activities.

(e) The Lehman center shall: (i) identify and disseminate information about evidence-based best practices to reduce medical errors and enhance patient safety; (ii) develop a process

for determining which evidence-based best practices should be considered for adoption; (iii) serve as a central clearinghouse for the collection and analysis of existing information on the causes of medical errors and strategies for prevention; and (iv) increase awareness of error prevention strategies through public and professional education. The information collected by the Lehman center or reported to the Lehman center shall not be a public record as defined in section 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding, except as otherwise specifically provided by law.

(f) Notwithstanding any general or special law to the contrary, the Lehman center and each agency that collects or maintains patient safety information may transmit such information, including personal data, as defined in section 1 of chapter 66A, to each other through an agreement, which may be an interagency service agreement, that provides for any safeguards necessary to protect the privacy and security of the information; provided, however, that the provision of the information is consistent with federal law.

(g) The Lehman center may adopt rules and regulations necessary to carry out this section. The Lehman center may contract with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity to manage its affairs or carry out this section.

(h) The Lehman center shall report annually to the general court regarding the progress made in improving patient safety and medical error reduction. The Lehman center shall seek federal and foundation support to supplement state resources to carry out the Lehman center's patient safety and medical error reduction goals.

SECTION 4 . Said chapter 12C is hereby further amended by inserting after section 20 the following section:-

Section 20A. The center shall, in collaboration with carriers and consumer representatives, develop a uniform methodology to communicate information on a provider's tier designation for use by patients, purchasers and employers to easily understand the differences between tiered health insurance plans and a provider's tier designation within a tiered health insurance plan.

SECTION 5 . Section 4 of chapter 32A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word "commonwealth", in line 12, the following words:- ; provided, however, that the carrier or third-party health care administrator website shall conform to the uniform methodology for a provider's tier designation pursuant to section 20A of chapter 12C.

SECTION 6 . Said chapter 32A is hereby further amended by adding the following section:-

Section 28. (a) As used in this section, "facility fee", "health system", "hospital" and "hospital-based facility" shall have the same meanings as provided in section 28 of chapter 176O.

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not impose a separate copayment on an insured or provide reimbursement to a hospital, health system or hospital-based facility for services provided at a hospital, health system or hospital-based facility or for reimbursement to any such hospital, health system or hospital-based facility for a facility fee for

services utilizing a current procedural terminology evaluation and management code or which is otherwise limited pursuant to section 51L of chapter 111.

A hospital, health system or hospital-based facility shall not charge, bill or collect from an insured a facility fee greater than the facility fee reimbursement rate agreed to by the carrier pursuant to an insured's policy.

(c) Nothing in this section shall prohibit the commission from offering coverage that restricts the reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

SECTION 7 . Said chapter 94C as appearing in the 2016 Official Edition, is hereby amended by inserting after section 21B the following section:-

Section 21C. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Cost sharing", amounts owed by a consumer under the terms of the consumer's health benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit manager as defined in subsection (a) of section 226 of chapter 175.

"Pharmacy retail price", the amount an individual would pay for a prescription medication at a pharmacy if the individual purchased that prescription medication at that pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any other prescription medication benefit or discount.

"Registered pharmacist", a pharmacist who holds a valid certificate of registration issued by the board of registration in pharmacy pursuant to section 24 of chapter 112.

(b) A pharmacy shall post a notice informing consumers that a consumer may request, at the point of sale, the current pharmacy retail price for each prescription medication the consumer intends to purchase. If the consumer's cost-sharing amount for a prescription medication exceeds the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient's cost-sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount or the current pharmacy retail price for that prescription medication, as directed by the consumer.

A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or a third party for failure to comply with this section.

(c) A contractual obligation shall not prohibit a pharmacist from complying with this section; provided, however, that a pharmacist shall submit a claim to the consumer's health benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the prescription medication is covered under the consumer's health benefit plan.

(d) A violation of this section shall be an unfair or deceptive act or practice under chapter 93A.

SECTION 8 . Chapter 111, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 51K the following section:-

Section 51L. (a) For the purposes of this section, the following terms shall have the following meanings unless the context clearly indicates otherwise:

"Campus", 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 not

more than 250 yards from the main buildings or any other area that has been determined on an individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's campus.

"Carrier", shall have the same meaning as provided in section 1 of chapter 176O.

"Facility fee", shall have the same meaning as provided in section 28 of chapter 176O.

"Health system", shall have the same meaning as provided in section 28 of chapter 176O.

"Hospital-based facility", shall have the same meaning as provided in section 28 of chapter 176O.

(b) A hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee for services utilizing a current procedural terminology evaluation and management code if the service was provided by a hospital-based facility located off of a campus unless the facility fee was charged, billed or collected by the hospital-based facility on or before July 1, 2017. A violation of this subsection shall be an unfair trade practice under chapter 93A.

(c) The department may identify additional conditions or factors that would prohibit a hospital, health system or hospital-based facility from charging, billing or collecting a facility fee for health care services. Additional conditions or factors may include, but shall not be limited to: (i) additional current procedural terminology codes for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; (ii) health care services for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; (iii) limitations on physical locations, including whether on a campus or not, for which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and

(iv) other conditions or factors. The department shall forward any recommendations under this subsection to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 9. Said chapter 111 is hereby further amended by inserting after section 70E the following section:-

Section 70E1/2. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

“Gross charges” means a health care provider’s full, established price for health care services that the health care provider charges patients without health insurance coverage before applying any contractual allowances, discounts, or deductions.

"Health care provider", a provider of medical or health services or any other person or organization that furnishes, bills or is paid for health care service delivery in the normal course of business.

"Health care services", supplies, care and services of medical, behavioral health, substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services; services provided by a community health center home health and hospice care provider, or by a sanatorium, as included in the definition of "hospital" in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

"Health insurance coverage" , (any (i) blanket or general policy of medical, surgical or hospital insurance described in subdivision (A), (C) or (D) of section one hundred and ten of chapter one hundred and seventy-five; (ii) policy of accident or sickness insurance as described in section one hundred and eight of chapter one hundred and seventy-five which provides hospital or surgical expense coverage; (iii) nongroup or group hospital or medical service plan issued by a non-profit hospital or medical service corporation under chapters one hundred and seventy-six A and one hundred and seventy-six B; (iv) nongroup or group health maintenance contract issued by a health maintenance organization under chapter one hundred and seventy-six G; (v) insured group health benefit plan that includes a preferred provider arrangement under chapter one hundred and seventy-six I; (vi) self-insured or self-funded employer group health plan; (vii) health coverage provided to persons serving in the armed forces of the United States; (viii) health coverage provided to persons under the Medicare program established by Title XVIII of the Federal Social Security Act; or (ix) medical assistance provided under chapter one hundred and eighteen E.

“Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of the University of Massachusetts Medical School or a psychiatric facility licensed under section 19 of chapter 19, and any person, agency or organization affiliated with the hospital or by whom services were rendered at the request of the hospital.

“Household income” means income calculated by using the methods used to calculate MassHealth eligibility, as set forth in 130 CMR 506.000.

"Patient", any natural person receiving health care services from a hospital OR health care provider.

"Provider organization", any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

“Medical debt” a debt arising from the receipt of health care services.

(b) Each hospital and health care provider that is a member of a provider organization shall establish a written financial assistance policy. This requirement shall apply whether or not that hospital or health care provider that is a member of a provider organization is required to develop a financial assistance policy under 26 U.S.C. § 501(r)(4).

A copy of the financial assistance policy, in plain English and in other languages spoken by patients in that hospital’s or health care provider that is a member of a provider organization’s service area, shall accompany any bill that seeks payment, in whole or in part, for gross charges from that hospital or health care provider that is a member of a provider organization

(c) that financial assistance policy shall, at a minimum, contain the following:

(1) clearly state that it applies to all health care services delivered by that hospital or health care provider that is a member of a provider organization;

(2) a plain language summary of the financial assistance policy, which shall not exceed two pages in length;

(3) the eligibility criteria for all financial assistance offered;

(4) the method and application process that patients are to use to apply for financial assistance, including but not limited to the name and telephone number of the person or office assigned to work with patients seeking financial assistance;

(5) a list of any required documentation that a patient will need to submit with the application for financial assistance;

(6) a list of the reasonable steps that the hospital or health care provider will take to determine a patient's eligibility for financial assistance, including but not limited to assisting the patient with applying for and using any health insurance coverage that may be available to them; and

(7) the billing and collections policy, including the actions that may be taken in the event of nonpayment, that is consistent with the requirements of this section and other applicable state or federal laws.

(d) The financial assistance policy must be approved by the owners or governing body of a hospital and health care provider that is a member of a provider organization, and thereafter shall be reviewed and approved on an annual basis by the owners or governing board.

(e) In addition to any other actions required by state or federal law, a hospital and health care provider that is a member of a provider organization shall implement a financial assistance plan for any charges for medically necessary health care services that are not included in the patient's health insurance coverage, if any, and would otherwise be billed to the patient, subject

to the requirements of section 228 of this chapter and sections 29 and 30 of chapter 176O, as follows:

(1) Patients with household income of 0 per cent through 200 per cent of the federal poverty level shall receive free care;

(2) Patients with household income of 201 per cent through 400 per cent of the federal poverty level shall be charged no more than the amount calculated in the following manner:

(i) Recalculate the patient's bill using the Medicare reimbursement rate applicable at the time health care services were provided;

(ii) The patient shall be charged no more than 50 per cent of the first $1,000 charged under this recalculated bill;

(iii) The patient shall be charged no more than 10 per cent of any remaining amount between $1,001–5,000;

(iv) The patient shall be charged no more than 5 per cent of any remaining amount between $5,001–10,000;

(v) Any amount above $10,000 shall be provided to the patient as free care.

(3) Patients with household income of 401 per cent through 600 per cent of the federal poverty level shall receive the same discounts as patients with household income of 201 per cent through 400 per cent of the federal poverty level if the patient and the patient's household can demonstrate though appropriate documentation that they have incurred medical expenses from a hospital or health care provider that is a member of a provider organization during the previous twelve months, the total of which exceeds 10 per cent of the household's annual gross income.

(4) In addition to other financial assistance provided under this section, no patient with household income at or below 400 per cent of the federal poverty level shall be required to pay more than $2,300 in cumulative medical bills to a hospital or health care provider that is a member of a provider organization per year. Upon patient request and documentation, any charges for medically necessary health care services that are not included in the patient's health insurance coverage, if any, and would otherwise be billed to the patient, subject to the requirements of section 228 of this chapter and sections 29 and 30 of chapter 176O, that have been delivered by one or more hospitals or health care providers that are a member of a provider organization after the $2,300 limit has been met after applying the limitation of this subsection must be provided as free care.

(f) Payments owed for health care services subject to the requirements of subsection (e) shall be interest free.

(g) Parents and legal guardians are jointly liable for any medical debt incurred by children under the age of 18.

No spouse or other person shall be liable for the medical debt of any other person age 18 or older. A person may voluntarily consent to assume liability, but such consent: (1) shall be on a separate standalone document signed by the person; (2) shall not be solicited in an emergency room or an emergency situation; and (3) shall not be a condition of providing any health care services.

(h) Nothing in this section shall be construed to diminish or eliminate any protections patients have under existing federal and state debt collection laws, or any other consumer

protections available under state or federal law, including but not limited to the Division of Medical Assistance—Health Safety Net Eligible Services, 101 CMR 613 et seq.

(i) A violation of this section shall be an unfair trade practice under chapter 93A

SECTION 10. Said chapter 111 is hereby further amended by striking out section 228, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

Section 228. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Allowed amount" shall mean the contractually agreed-upon amount paid by a carrier to a health care provider for health care services provided to an insured.

"Carrier", as defined in section 1 of chapter 176O.

"Emergency medical condition", as defined in section 1 of chapter 176O.

"Facility", as defined in section 1 of chapter 6D.

"Facility fee", a fee charged or billed by a health care provider, health care provider group or a hospital for outpatient hospital services provided in a hospital-based facility that is intended to compensate the health care provider, health care provider group or a hospital for the operational expenses and is separate and distinct from a professional fee.

"Hospital", as defined in section 1 of chapter 6D.

"Hospital-based facility", a facility that is owned or operated, in whole or in part, by a health care provider, health care provider group or a hospital where health care services are provided.

"Insured", as defined in section 1 of chapter 176O.

"Network provider", a participating provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds enrolled in any or all of the carrier's network plans, policies, contracts or other arrangements.

"Network status", a designation to distinguish between a network provider and an out-of-network provider.

"Out-of-network provider", a provider, other than a person licensed under Chapter 111C, that does not participate in the network of an insured's health benefit plan because: (i) the provider contracts with a carrier to participate in the carrier's network but does not contract as a participating provider for the specific health benefit plan to which an insured is enrolled; or (ii) the provider does not contract with a carrier to participate in any of the carrier's network plans, policies, contracts or other arrangements.

"Prior written consent", a signed written consent form provided to a patient or prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-network provider rendering health care services, other than for emergency services, when said services are scheduled at least 24 hours in advance of the rendering of care, to such patient or prospective patient or, if that person lacks capacity to consent, signed by the person authorized to consent for such a patient or prospective patient. A prior written consent form shall be presented in a manner and format to be determined by the commissioner of public health in consultation with the division of insurance;; provided, that such consent form shall be a document that is separate from any other document used to obtain the consent of the patient or prospective patient for any other part of the care or procedure; and provided further, that such consent form shall

include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-network¬ status to the patient or prospective patient; (ii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services rendered by an out-of-network provider may result in costs not covered by the patient's or prospective patient's carrier or specific health benefit plan; (iii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services may be available from a contracted provider and that the patient or prospective patient is not required to obtain care from the out-of-network provider; (iv) a statement affirming that the out-of-network provider presented the patient or prospective patient with a written estimate of the patient or prospective patient's total out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative declaration of the patient's or prospective patient's consent to receive health care services from the out-of-network provider, signed by the patient or prospective patient, or by the person authorized to consent for such a patient or prospective patient.

(b) At the time of scheduling an admission, procedure or service for an insured patient or prospective patient, a health care provider shall: (i) determine the provider's own network status relative to insured's insurance carrier and specific health benefit plan and disclose in real time such network status to the insured; (ii) notify the patient or prospective patient of their right to request and obtain from the provider, based on information available to the provider at the time of the request, additional information on the network status of any provider reasonably expected to render services in the course of such admission, procedure or service that is necessary for the patient's or prospective patient's use of a health benefit plan's toll-free number and website available pursuant to section 23 of chapter 176O to obtain additional information about that provider's network status under the patient's or prospective patient's health benefit plan and any

applicable out-of-pocket costs for services sought from such provider; (iii) notify the patient or prospective patient of their right to request and obtain from the provider, based on information available to the provider at the time of the request, information on such admission, procedure or service that is necessary for the patient's or prospective patient's use of a health benefit plan's toll-free number and website available pursuant to section 23 of chapter 176O to identify the allowed amount or charge of the admission, procedure or service, including the amount for any facility fees required; (iv) notify the patient or prospective patient that in the event a health care provider is unable to quote a specific allowed amount or charge in advance of the admission, procedure or service due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose to the patient or prospective patient the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount for any facility fees required; and (iv) inform the patient or prospective patient that the estimated costs and the actual amount the patient or prospective patient may be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service. This subsection shall not apply in cases of services provided to a patient to treat an emergency medical condition.

(c) If a network provider schedules, orders or otherwise arranges for services related to an insured's admission, procedure or service and such services are performed by another health care provider, or if a network provider refers an insured to another health care provider for an admission, procedure or service, then in addition to the actions required pursuant to subsection (b) the network provider shall, based on information available to the provider at that time: (i) disclose to the insured if the provider to whom the patient is being referred is part of or represented by the same provider organization registered pursuant to section 11 of chapter 6D;

(ii) disclose to the insured sufficient information about such provider for the patient to obtain information about that provider's network status under the insured's health benefit plan and identify any applicable out-of-pocket costs for services sought from such provider through the toll-free number and website of the insurance carrier available pursuant to section 23 of chapter 176O; and (iii) notify the insured that if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply. This subsection shall not apply in cases of services provided to a patient to treat an emergency medical condition.

(d) Upon initial encounter with a patient at the time of scheduling an admission, procedure or service for an insured patient or prospective patient, an out-of-network provider shall, in addition to the actions required pursuant to subsection (b) and at least 24 hours in advance of care, when said care is scheduled at least 24 hours in advance of rendering the services: (i) disclose to the insured that the provider does not participle in the insured's health benefit plan network; (ii) provide the insured with the estimated or maximum charge that the provider will bill the insured for the admission, procedure or service if rendered as an out-of-network service, including the amount of any facility fees; (iii) inform the patient or prospective patient that additional information on applicable out-of-pocket costs for out-of-network services may be obtained through the toll-free number and website of the insurance carrier available pursuant to section 23 of chapter 176O; and (iv) obtain the prior written consent of such patient or prospective patient in advance of the out-of-network provider rendering health care services. This subsection shall not apply in cases of services provided to a patient to treat an emergency medical condition..

SECTION 11 . Section 1 of chapter 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of “Incentive plan” the following definition:-

“In-network contracted rate”, the rate contracted between an insured's carrier and a network health care provider for the reimbursement of health care services delivered by that health care provider to the insured.

SECTION 12 . Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following 3 definitions:-

“Noncontracted commercial rate for emergency services”, the amount set pursuant to section 16A of chapter 6D and used to determine the rate of payment to a health care provider for the provision of emergency health care services to an insured when the health care provider is not in the carrier’s network.

“Noncontracted commercial rate for nonemergency services”, the amount set pursuant to section 16A of chapter 6D and used to determine the rate of payment to a health care provider for the provision of nonemergency health care services to an insured when the health care provider is not in the carrier’s network.

“Nonemergency services”, health care services rendered to an insured experiencing a condition other than an emergency medical condition.

SECTION 13 . Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Office of patient protection” the following definition:-

"Out-of-network provider", a provider, other than a person licensed under Chapter 111C, that does not participate in the network of an insured's health benefit plan because: (i) the provider contracts with a carrier to participate in the carrier's network but does not contract as a participating provider for the specific health benefit plan to which an insured is enrolled; or (ii) the provider does not contract with a carrier to participate in any of the carrier's network plans, policies, contracts or other arrangements.

SECTION 14. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; and (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall 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 affirmatively chooses to receive services from an out-of-network provider and the out-of-network provider has obtained the prior written consent of the insured pursuant to section 228 of chapter 111.

SECTION 15 . Subsection (a) of said section 6 of said chapter 176O, as so appearing, is hereby further amended by striking out clause (8) and inserting in place thereof the following clause:-

(8)(i) a clear description of the procedure, if any, by which the insured may request an out-of-network referral; (ii) a summary description of the methodology used by the insurer to determine reimbursement of out-of-network health care services; (iii) the amount that the insurer will reimburse under the methodology pursuant to sections 29 and 30 ; and (iv) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

SECTION 16. Section 23 of said chapter 176O, as so appearing, is hereby amended by striking out section 23, as so appearing in the 2016 2016 Official Edition, and inserting in place thereof the following section:-

Section 23. 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 and 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. All carriers shall create a mechanism by which the insured can request notice of the estimated amount in writing. Upon request, the carrier shall send the consumer written notice of the estimated amount the insured will be responsible for paying.

The telephone number and website shall inform the insured that the insured shall not be required to pay more than the estimated amounts disclosed in the written notice 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 document provided by the carrier 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, except that the insured shall not be responsible for any additional payment caused by the carrier mistakenly identifying an out-of-network provider as in-network.

The information provided on the website shall conform to the uniform methodology for a provider’s tier designation developed pursuant to section 20A of chapter 12C.

SECTION 1 7. Said chapter 176O is hereby further amended by adding the following 5 sections:-

Section 28. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

“Facility fee”, a fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is intended to compensate the hospital or health system for the operational expenses of the hospital or health system and is separate and distinct from a professional fee.

“Health system”, shall have the same meaning as “Provider Organization or Health System or System”, as provided by the health policy commission.

“Hospital”, a hospital licensed pursuant to section 51 of chapter 111.

“Hospital-based facility”, 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.

“Professional fee”, a fee charged or billed by a provider, hospital or health system for professional medical services provided in a hospital-based facility.

(b) If a hospital or health system charges a facility fee for services that are not subject to the limitations of section 51L of chapter 111, the hospital or health system shall provide any patient receiving such a service with written notice of the fee. The notice shall the following: (i) a statement of disclosure informing the patient that the hospital, hospital-based facility, or provider has charged or billed a facility fee that is in addition to and separate from the professional fee charged by the provider; (ii) the amount of the facility fee charged or billed, or, if the exact type and extent of the facility fee is not known with reasonable certainty, an estimate of the facility fee; (iii) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient; (iv) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and (v) that a patient covered by a health insurance policy should contact the health insurer to receive information about alternative providers that do not charge a facility fee.a statement that the patient may be billed separately for that facility fee and the expected amount of the facility fee.

(c) If a hospital or health system is required to provide a patient with notice under subsection (b) and a patient's admission, procedure or service is scheduled to occur not less than 10 days after the appointment is made, the hospital or health system shall 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 given orally at the time the patient makes the appointment, and written notice shall be provided to the patient prior to the service when the patient arrives at the hospital or provided to the patient on the hospital-based facility's premises.

For emergency care, a hospital or health system shall provide written notice and explanation to the patient prior to the care if practicable, or if notice is not practicable, the hospital or health system shall provide an explanation of the fee to the patient within a reasonable period of time; provided, however, that the explanation of the fee shall be provided before the patient leaves the hospital-based 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 shall be provided to the patient's representative within a reasonable period of time.

(d) A hospital-based facility shall clearly identify itself as being hospital-based, including by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(e) If a hospital-based facility charges a facility fee, notice shall be posted informing patients that a patient may incur additional financial liability due to the hospital-based facility's status. Notice shall be prominently displayed on the website of the hospital-based facility, and in locations accessible to and visible by patients, including in patient waiting areas.

(f) (1) If a hospital or health system designates a location as a hospital-based facility, the hospital or health system shall provide written notice of the designation to all patients who

received services at the now designated hospital-based facility during the previous calendar year. The written notice shall be provided not later than 30 days after the designation and shall state that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care services delivered at the facility may result in separate bills for services from the hospital and the provider; and (iii) patients seeking care at the facility may incur additional financial liability at that location due its hospital-based facility status.

(2) If a hospital or health system designates a location as a hospital-based facility, the hospital or health system shall not collect a facility fee for a service provided at the now designated hospital-based facility until not less than 30 days after the written notice required in paragraph (1) is mailed.

(3) A notice required or provided under paragraph (1) or (2) shall be filed with the health policy commission established under section 2 of chapter 6D not later than 30 days after its issuance.

(g) The notices and statements required under this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. All notices under this section shall be available in all languages representative of that health care provider's patient population.

(h) A violation of this section shall be an unfair trade practice under chapter 93A.

(i) The commissioner may promulgate regulations that are necessary to implement this section subject to the limitations of section 16A of chapter 6D.

Section 29. (a) As used in this section, “facility fee”, “health system”, “hospital” and “hospital-based facility” shall have the meanings as provided in section 28.

(b) A carrier shall not impose a separate copayment on an insured or provide reimbursement to a hospital, health system or hospital-based facility for services provided at a hospital, health system or a hospital-based facility or for reimbursement to such a hospital, health system or hospital-based facility for a facility fee for services utilizing a current procedural terminology evaluation and management code or otherwise prohibited pursuant to section 51L of chapter 111.

(c) Nothing in this section shall prohibit a carrier from restricting the reimbursement of facility fees beyond the limitations set forth in section 51K of chapter 111.

Section 30. (a)(1) A carrier shall reimburse a health care provider as follows:

(i) where the health care provider is a member of an insured’s carrier’s network but not a participating provider in the insured’s health benefit plan and the health care provider has delivered health care services to the insured to treat an emergency medical condition, the carrier shall pay that provider the in-network contracted rate for each delivered service; provided, however, that such payment shall constitute payment in full to that health care provider and the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service or services from a participating health care provider under the terms of the insured’s health benefit plan;

(ii) where the health care provider is not a member of an insured’s carrier’s network and the health care provider has delivered health care services to the insured to treat an emergency medical condition, the carrier shall pay that provider the noncontracted commercial rate for

emergency services for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service or services from a participating health care provider under the terms of the insured's health benefit plan;

(iii) where the health care provider is a member of an insured's carrier's network but not a participating provider in the insured's health benefit plan and the health care provider has delivered nonemergency health care services to the insured and a participating provider in the insured's health benefit plan is unavailable or the health care provider renders those nonemergency health care services without the insured's knowledge, the carrier shall pay that provider the in-network contracted rate for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service from a participating health care provider under the terms of the insured's health benefit plan; and

(iv) where the health care provider is not a member of an insured's carrier's network and the health care provider has delivered nonemergency services to the insured and a participating provider in the insured's health benefit plan is unavailable or the health care provider renders those nonemergency health care services without the insured's knowledge, the carrier shall pay the provider the noncontracted commercial rate for nonemergency services for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the provider shall not bill the insured except for any applicable copayment,

coinsurance or deductible that would be owed if the insured received such service or services from a participating health care provider under the terms of the insured's health benefit plan.

(2) It shall be an unfair and deceptive act or practice, in violation of section 2 of chapter 93A, for any health care provider or carrier to request payment from an enrollee, other than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services described in paragraph (1).

(b) Nothing in this section shall require a carrier to pay for health care services delivered to an insured that are not covered benefits under the terms of the insured's health benefit plan.

(c) Nothing in this section shall require a carrier to pay for nonemergency health care services delivered by an out-of-network provider that has obtained prior written consent pursuant to section 228 of chapter 111.

(d) The commissioner shall promulgate regulations that are necessary to implement this section.

Section 31 . (a) A carrier shall ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan and shall review and update the entire provider directory for each network plan. In making the directory available electronically in a searchable format, the carrier shall ensure that the general public is able to view all of the current health care providers for a network plan through a clearly identifiable link or tab and without creating or accessing an account, entering a policy or contract number, providing other identifying information, or demonstrating coverage or an interest in obtaining coverage with the network plan. Thereafter, the carrier shall update each online network plan provider directory at least monthly, or more frequently, if required by state or federal law or

regulations promulgated by the commissioner pursuant to Section 32(j), when informed of and upon confirmation by the plan of any of the following:

(1) A contracting provider is no longer accepting new patients for that network plan, or an individual provider within a provider group is no longer accepting new patients.

(2) A provider or provider group is no longer under contract for a particular network plan.

(3) A provider's practice location or other information required under this section has changed.

(4) Upon completion of the investigation described in paragraph (a)(4), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(5) A provider has retired or otherwise has ceased to practice.

(6) Any other information that affects the content or accuracy of the provider directory or directories.

(b) A provider directory shall not list or include information on a provider that is not currently under contract with the network plan.

(c) A carrier shall periodically audit its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(d) A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory upon request of an insured or a prospective insured. The printed copy of the provider directory or directories shall be provided to the requester by

mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(e) The carrier shall include in both its electronic and print directories a dedicated customer service email address and telephone number or electronic link that insureds, providers and the general public may use to notify the carrier of inaccurate provider directory information. This information shall be disclosed prominently in the directory or directories and on the carrier's web site. The carrier shall be required to investigate reports of inaccuracies within 30 days of notice and modify the directories in accordance with any findings within 30 days of such findings.

(f) The provider directory or directories shall inform enrollees and potential enrollees that they are entitled to: (A) language interpreter services, at no cost to the enrollee; and (B) full and equal access to covered services as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency, including how to obtain interpretation and translation services.

(g) The carrier shall include a disclosure in the print directory that the information included in the directory is accurate as of the date of printing and that insureds or prospective insureds should consult the carrier's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information.

(h) The carrier shall update its printed provider directory or directories at least annually, or more frequently, if required by federal law or regulations promulgated by the commissioner.

Section 32. (a) The division shall establish a task force to develop recommendations to ensure the current and accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public.

(b) The task force shall consist of the commissioner of insurance or a designee, who shall serve as chair, and 12 members: one of whom shall be a representative of the Massachusetts Association of Health Plans, one of whom shall be a representative of Blue Cross Blue Shield MA, one of whom shall be a representative of the Massachusetts Health and Hospital Association, one of whom shall be a representative of the Massachusetts Medical Society, one of whom shall be a representative of Healthcare Administrative Solutions, Inc., one of whom shall be a representative of the Children's Mental Health Campaign, one of whom shall be a representative of the Massachusetts Association for Mental Health, and five members chosen by the commissioner: one of whom shall have expertise in the treatment of individuals with substance use disorder, one of whom shall have expertise in the treatment of individuals with a mental illness, one of whom shall be from a health consumer advocacy organization, one of whom shall be a consumer representative, and one of whom shall be a representative from an employer group. The task force shall have the ability to form workgroups to develop the recommendations defined in subsection (a).

(c) The recommendations shall include measures for ensuring the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan. The task force shall develop recommendations that establish substantially similar processes

and time frames for health care providers included in a carrier's network to provide information to the carrier, and substantially similar processes and timeframes for carriers to include such information in their provider directories, regarding the following:

(1) when a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients, or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;

(2) when a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider may direct the enrollee or potential enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately if they have not done so already that the provider is not accepting new patients;

(3) when a provider is no longer under contract for a particular network plan;

(4) when a provider's practice location or other information required under this section has changed;

(5) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv) participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility affiliations, if applicable; (xii) languages spoken other than English, if applicable; (xiii) whether accepting new patients; and (xiv) information on access for people with disabilities, including

but not limited to structural accessibility and presence of accessible examination and diagnostic equipment;

(6) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location and telephone number; (iv) hospital accreditation status; (7) for facilities, other than hospitals, by type: (i) facility name; (ii) facility type; (iii) types of services performed; (iv) participating facility location(s) and telephone number; and

(7) Any other information that affects the content or accuracy of the provider directory or directories.

(d) The task force shall develop recommendations for carriers to include information in the provider directory that identifies the tier level for each specific provider, hospital or other type of facility in the network, when applicable.

(e) The task force shall develop recommendations for carriers to include in the provider directories substantially similar language to assist insureds with understanding and searching for behavioral health specialty providers.

(f) The task force shall consider the feasibility of carriers making updates to each online network plan provider directory in real time when health care providers included in a carrier's network provide information to the carrier pursuant to subsection (c).

(g) The task force shall consider measures to address circumstances when an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory.

(h) The task force shall develop recommendations for measures carriers shall take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers, as described in paragraph (c), including but not limited to periodic testing to ensure that the public interface of the directories accurately reflects the provider network, as required by state and federal laws and regulations.

(i) The task force shall recommend appropriate timelines for completion of its recommendations.

(j) The commissioner shall file the task force’s recommendations, including any proposed regulations, with the joint committee on health care financing not later than June 30, 2019.

(k) The commissioner shall promulgate regulations pursuant to section 30 and the recommendations of the task force no later than three months following the commissioner’s filing under subsection (j).

(l) The commissioner shall conduct quarterly implementation progress reports, which shall be available to the public, commencing on September 1, 2019 and continuing until the task force recommendations under subsection (j) are fully implemented.

SECTION 1 8. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for nonemergency services under chapter 176O of the General Laws shall be not more than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database by a nonprofit organization

specified by the division of insurance. Such an organization shall not be affiliated with a health carrier.

SECTION 19. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for emergency services under chapter 176O of the General Laws shall be not more than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database by a nonprofit organization specified by the division of insurance. Such an organization shall not be affiliated with any health carrier.

SECTION 20 . Sections 18 and 19 are hereby repealed.

SECTION 21 . The center for health information and analysis shall report on the implementation of facility fee protections under section 28 of chapter 32A, section 51L of chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall include: (i) facility fees charged or billed to provide a baseline report on facility fees that were charged or billed; and (ii) a 5-year status report.

The reports shall include: (i) the number of hospital-based facilities owned or operated by a hospital or health system that provides services for which a facility fee was charged or billed, broken down by hospital or health system; (ii) the number of patient visits provided at each hospital based facility for which a facility fee was charged or billed; (iii) the number of claims, total amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and private insurance policies, including any cost sharing, as applicable; (iv) the total amount of revenue from hospital-based facility fees received by a hospital or health system, categorized by

whether a hospital-based facility is on a campus; (v) separately for on-campus and off-campus hospital-based facilities, a description of the 10 procedures or services that generated the greatest amount of facility fee revenue at hospital-based facilities and, for each such procedure or service, the total amount of revenue received by a hospital or health system from the facility fees for the services; and (vi) the top 10 procedures or services for which facility fees were charged based on volume of claims.

The center for health information and analysis shall make the information publicly available on its website. The baseline report shall be made available on December 31, 2020 and the 5-year status report shall be made available on January 1, 2025.

SECTION 22 . Section 1 shall apply to plans submitted to the division of insurance on or after January 1, 2021.

SECTION 23 . Section 20 shall take effect on December 31, 2020.

SECTION 2 4. Notwithstanding any general or special law to the contrary, carriers shall ensure the accuracy of the information pursuant to the regulations issued by the commissioner of insurance pursuant to section 31 of chapter 176O of the general laws for each network plan no later than January 1, 2020.