

**HOUSE . . . . . No. 1197**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

*Jon Santiago*

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to out-of-network billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Jon Santiago</i>	<i>9th Suffolk</i>	<i>2/11/2021</i>
<i>Patrick Joseph Kearney</i>	<i>4th Plymouth</i>	<i>2/26/2021</i>
<i>Paul McMurtry</i>	<i>11th Norfolk</i>	<i>2/26/2021</i>
<i>James J. O'Day</i>	<i>14th Worcester</i>	<i>2/26/2021</i>
<i>John Barrett, III</i>	<i>1st Berkshire</i>	<i>2/26/2021</i>
<i>Brian W. Murray</i>	<i>10th Worcester</i>	<i>2/26/2021</i>
<i>Carlos González</i>	<i>10th Hampden</i>	<i>2/26/2021</i>

**HOUSE . . . . . No. 1197**

By Mr. Santiago of Boston, a petition (accompanied by bill, House, No. 1197) of Jon Santiago and others relative to out-of-network billing in health insurance. Financial Services.

**The Commonwealth of Massachusetts**

In the One Hundred and Ninety-Second General Court  
(2021-2022)

An Act relative to out-of-network billing.

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

1 SECTION 1. Section 1 of chapter 176O of the General Laws, as appearing in the 2016  
2 Official Edition, is hereby amended by inserting after the definition of “Emergency medical  
3 condition” the following definition:

4 "Emergency services", health care services rendered to treat an emergency medical  
5 condition.

6 SECTION 2. Said section 1 of said chapter 176O, as so appearing, is hereby further  
7 amended by inserting after the definition of “Incentive plan” the following 2 definitions:

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

11 “In-network cost-sharing amount”, the cost-sharing amount that the insured is required to  
12 pay for a covered health care service received from a network provider. Cost sharing includes

13 any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured  
14 other than premium or share of premium.

15 SECTION 3. Said section 1 of said chapter 176O, as so appearing, is hereby further  
16 amended by inserting after the definition of “Network” the following 2 definitions:

17 “Network facility”, a participating facility that, under a contract with the carrier or with  
18 its contractor or subcontractor, has agreed to provide health care services or a health care setting  
19 to insureds enrolled in any or all of the carrier's network plans, policies, contracts or other  
20 arrangements.

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

24 SECTION 4. Said section 1 of said chapter 176O, as so appearing, is hereby further  
25 amended by inserting after the definition of “Office of patient protection” the following  
26 definition:

27 “Out-of-network facility”, a facility that does not participate in the network of an  
28 insured’s health benefit plan.

29 “Out-of-network provider”, a provider, other than a person licensed under Chapter 111C,  
30 that does not participate in the network of an insured’s health benefit plan because: (i) the  
31 provider contracts with a carrier to participate in the carrier’s network but does not contract as a  
32 participating provider for the specific health benefit plan to which an insured is enrolled; or (ii)

33 the provider does not contract with a carrier to participate in any of the carrier's network plans,  
34 policies, contracts or other arrangements.

35 SECTION 5. Said section 1 of said chapter 176O, as so appearing, is hereby further  
36 amended by inserting after the definition of “Adverse determination” the following definition:

37 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health  
38 care provider for health care services provided to an insured.

39 SECTION 6. Said chapter 176O of the General Laws is hereby further amended by  
40 adding the following 5 sections:

41 Section 28. (a) For purposes of this section, an item or service furnished by an out-of-  
42 network provider during a year and a group health plan or group or individual health insurance  
43 coverage offered by a health insurance issuer, the total amount payable under such a plan,  
44 coverage, or issuer, respectively in the case of a participant, beneficiary, or enrollee covered  
45 under such plan or coverage and receiving such item or service from such an out-of-network  
46 provider, shall be paid in accordance with the determination of the qualifying payment amount as  
47 applicable under this section.

48 (b) The term ‘qualifying payment amount’ means, subject to subsections (c) and (d), with  
49 respect to a sponsor of a group health plan and health insurance issuer offering group or  
50 individual health insurance coverage—

51 (1) for an item or service furnished during 2022, the median of the contracted rates  
52 recognized by the plan or issuer, respectively, determined with respect to all such plans of such  
53 sponsor or all such coverage offered by such issuer that are offered within the same insurance

54 market as the total maximum payment (including the cost-sharing amount imposed for such item  
55 or service and the amount to be paid by the plan or issuer, respectively) under such plans or  
56 coverage, respectively, on January 31, 2019, for the same or a similar item or service that is  
57 provided by a provider in the same or similar specialty and provided in the geographic region in  
58 which the item or service is furnished, consistent with the methodology established under  
59 Section 2799A – 1 (a)(2)(B) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg  
60 et seq.), increased by the percentage increase in the consumer price index for all urban  
61 consumers (United States city average) over 2019, such percentage increase over 2020, and such  
62 percentage increase over 2021; and

63 (2) for an item or service furnished during 2023 or a subsequent year, the qualifying  
64 payment amount determined under this section for such an item or service furnished in the  
65 previous year, increased by the percentage increase in the consumer price index for all urban  
66 consumers (United States city average) over such previous year.

67 (c) The term ‘qualifying payment amount’ means, with respect to a sponsor of a group  
68 health plan or health insurance issuer offering group or individual health insurance coverage in a  
69 geographic region in which such sponsor or issuer, respectively, did not offer any group health  
70 plan or health insurance coverage during 2019—

71 (1) for the first year in which such group health plan, group health insurance coverage, or  
72 individual health insurance coverage, respectively, is offered in such region, a rate (determined  
73 in accordance with the methodology established under subsection (b) above) for items and  
74 services that are covered by such plan or coverage and furnished during such first year; and

75 (2) for each subsequent year such group health plan, group health insurance coverage, or  
76 individual health insurance coverage, respectively, is offered in such region, the qualifying  
77 payment amount determined under this section for such items and services furnished in the  
78 previous year, increased by the percentage increase in the consumer price index for all urban  
79 consumers (United States city average) over such previous year.

80 (d) In the case of a sponsor of a group health plan or health insurance issuer offering  
81 group or individual health insurance coverage that does not have sufficient information to  
82 calculate the median of the contracted rates described in subsection (b)(1) in 2019 (or, in the case  
83 of a newly covered item or service (as defined in subsection (f)(iii)), in the first coverage year (as  
84 defined in subsection (f)(1))) for such item or service with respect to such plan or coverage) for  
85 an item or service (including with respect to provider type, or amount, of claims for items or  
86 services provided in a particular geographic region (other than in a case with respect to which  
87 subsection (c) applies)) the term ‘qualifying payment amount’—

88 (1) for an item or service furnished during 2022 (or, in the case of a newly covered item  
89 or service, during the first coverage year for such item or service with respect to such plan or  
90 coverage), means such rate for such item or service determined by the sponsor or issuer,  
91 respectively, through use of any database that is determined not to have any conflicts of interest  
92 and to have sufficient information reflecting allowed amounts paid to a health care provider or  
93 facility for relevant services furnished in the applicable geographic region;

94 (2) for an item or service furnished in a subsequent year (before the first sufficient  
95 information year (as defined in subsection (f)(2)) for such item or service with respect to such  
96 plan or coverage), means the rate determined under subsection (b) or this subsection, as

97 applicable, for such item or service for the year previous to such subsequent year, increased by  
98 the percentage increase in the consumer price index for all urban consumers (United States city  
99 average) over such previous year;

100 (3) for an item or service furnished in the first sufficient information year for such item or  
101 service with respect to such plan or coverage, has the meaning given the term qualifying  
102 payment amount in subsection (b)(1), except that in applying such clause to such item or service,  
103 the reference to ‘furnished during 2022’ shall be treated as a reference to furnished during such  
104 first sufficient information year, the reference to ‘in 2019’ shall be treated as a reference to such  
105 sufficient information year, and the increase described in such clause shall not be applied; and

106 (4) for an item or service furnished in any year subsequent to the first sufficient  
107 information year for such item or service with respect to such plan or coverage, has the meaning  
108 given such term in clause (c)(ii), except that in applying such clause to such item or service, the  
109 reference to ‘furnished during 2023 or a subsequent year’ shall be treated as a reference to  
110 furnished during the year after such first sufficient information year or a subsequent year.

111 (e) For purposes of subsection (b)(1), a health insurance market specified in this  
112 subsection is one of the following:

113 (1) The individual market.

114 (2) The large group market (other than plans described in paragraph (4)).

115 (3) The small group market (other than plans described in paragraph (4)).

116 (4) In the case of a self-insured group health plan, other self-insured group health plans.

117 (f) For purposes of this section:

118 (1) The term ‘first coverage year’ means, with respect to a group health plan or group or  
119 individual health insurance coverage offered by a health insurance issuer and an item or service  
120 for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019  
121 for which coverage for such item or service is offered under such plan or health insurance  
122 coverage.

123 (2) The term ‘first sufficient information year’ means, with respect to a group health plan  
124 or group or individual health insurance coverage offered by a health insurance issuer—

125 (A) in the case of an item or service for which the plan or coverage does not have  
126 sufficient information to calculate the median of the contracted rates described in subsection  
127 (b)(1) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such  
128 sufficient information to calculate the median of such contracted rates in the year previous to  
129 such first subsequent year; and

130 (B) in the case of a newly covered item or service, the first year subsequent to the first  
131 coverage year for such item or service with respect to such plan or coverage for which the  
132 sponsor or issuer has sufficient information to calculate the median of the contracted rates  
133 described in subsection (b)(1) in the year previous to such first subsequent year.

134 (3) The term ‘newly covered item or service’ means, with respect to a group health plan  
135 or group or individual health insurance issuer offering health insurance coverage, an item or  
136 service for which coverage was not offered in 2019 under such plan or coverage, but is offered  
137 under such plan or coverage in a year after 2019.

138 (g) An out-of-network provider who, on a case-by-case basis, determines to waive a cost  
139 for an insured in a health benefit plan based upon economic circumstances of the insured,



140 including any deductible, copayment, or coinsurance amount, shall, for such action, not be  
141 subject to any of the following:

142 (1) a civil cause of action by a health benefit plan,

143 (2) prosecution for a violation of this chapter in a court of competent jurisdiction,

144 (3) a sanction before any state oversight or licensing board, or

145 (4) an approval requirement of a health benefit plan.

146 Section 29. (a) If a carrier provides or covers any benefits with respect to services in an  
147 emergency department of a hospital or with respect to emergency services in an independent  
148 freestanding emergency department, the carrier shall cover emergency services—

149 (1) without the need for any prior authorization determination;

150 (2) whether the health care provider furnishing such services is a network provider with  
151 respect to such services;

152 (3) in a manner so that, if such services are provided to a participant, beneficiary, or  
153 enrollee by an out-of-network provider—

154 (A) such services will be provided without imposing any requirement under the plan or  
155 coverage for prior authorization of services or any limitation on coverage that is more restrictive  
156 than the requirements or limitations that apply to emergency services received from network  
157 providers with respect to such plan or coverage, respectively;

158 (B) the cost-sharing requirement is not greater than the in-network cost-sharing amount;

159 (C) such cost-sharing requirement is calculated as if the total amount that would have  
160 been charged for such services by such network provider were equal to the qualifying payment  
161 amount for such services, plan or coverage, and year;

162 (D) the carrier—

163 (i) not later than 30 calendar days after the bill for such services is transmitted by such  
164 provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of  
165 denial of payment; and

166 (ii) pays a total plan or coverage payment directly to such provider or facility,  
167 respectively that is, with application of any initial payment under subclause (I), equal to the  
168 amount by which the qualifying payment amount for such services exceeds the cost-sharing  
169 amount for such services (as determined in accordance with subsections (B) and (C)) and year

170 (E) any cost-sharing payments made by the participant, beneficiary, or enrollee with  
171 respect to such emergency services so furnished shall be counted toward any in-network  
172 deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and  
173 such in-network deductible and out-of-pocket maximums shall be applied) in the same manner  
174 as if such cost-sharing payments were made with respect to emergency services furnished by a  
175 network provider; and

176 (4) without regard to any other term or condition of such coverage (other than exclusion  
177 or coordination of benefits, or an affiliation or waiting period, permitted under 29 CFR §  
178 2590.715-2704, including as incorporated pursuant to section 715 of the Employee Retirement  
179 Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other  
180 than applicable cost-sharing).

181           Section 30. (a) With respect to an item or service furnished in a year by an out-of-  
182 network provider, with respect to a carrier offering group or individual health insurance  
183 coverage, with respect to such carrier or coverage and provider or facility, and for which a  
184 payment is required to be made by the carrier or coverage, the provider or facility (as applicable)  
185 or carrier or coverage may, during the 15-day period beginning on the day the provider or facility  
186 receives an initial payment or a notice of denial of payment from the plan or coverage regarding  
187 a claim for payment for such item or service, initiate open negotiations under this paragraph  
188 between such provider or facility and carrier or coverage for purposes of determining, during the  
189 open negotiation period, an amount agreed on by such provider or facility, respectively, and such  
190 carrier or coverage for payment (including any cost-sharing) for such item or service. For  
191 purposes of this subsection, the open negotiation period, with respect to an item or service, is the  
192 15-day period beginning on the date of initiation of the negotiations with respect to such item or  
193 service.

194           (b) In the case of open negotiations pursuant to subsection (a), with respect to an item or  
195 service, that do not result in a determination of an amount of payment for such item or service by  
196 the last day of the open negotiation period described in such subsection with respect to such item  
197 or service, the provider or facility (as applicable) or carrier offering group or individual health  
198 insurance coverage that was party to such negotiations may, during the 4-day period beginning  
199 on the day after such open negotiation period, initiate the independent dispute resolution process  
200 under subsection (c) with respect to such item or service. The independent dispute resolution  
201 process shall be initiated by a party pursuant to the previous sentence by submission to the other  
202 party of a notification (containing such information as specified under subsection (c)) and for  
203 purposes of this subsection, the date of initiation of such process shall be the date of such

204 submission or such other date specified pursuant to regulations that is not later than the date of  
205 receipt of such notification by the other party.

206 (c) In the case of an item or service with respect to which a provider or facility (as  
207 applicable) or group health plan submits a notification under subsection (b) (in this Section  
208 referred to as a ‘qualified IDR item or service’), a certified IDR entity under Section 2799A–1  
209 (c) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) shall determine the  
210 amount of payment under the plan for such item or service furnished by such provider or facility.

211 (d) Under the IDR process as established by Section 2799A–1 (c)(1)(A)(2) of Title  
212 XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), in the case that the parties to  
213 a determination for a qualified IDR item or service agree on a payment amount for such item or  
214 service during such process but before the date on which the IDR entity selected makes a  
215 determination under subsection (c), such amount shall be treated as the amount agreed to by such  
216 parties for such item or service. In the case of an agreement described in the previous sentence,  
217 the independent dispute resolution process shall provide for a method to determine how to  
218 allocate between the parties to such determination the payment of the compensation of the entity  
219 selected with respect to such determination.

220 (e) Under the IDR process as established by Section 2799A–1 (c)(1)(A)(2) of Title  
221 XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), multiple qualified IDR items  
222 and services are permitted to be considered jointly as part of a single determination by an entity  
223 for purposes of encouraging the efficiency (including minimizing costs) of the IDR process.  
224 Such items and services may be so considered only if—

225 (1) such items and services to be included in such determination are furnished by the  
226 same provider or facility;

227 (2) payment for such items and services is required to be made by the same carrier; and

228 (3) such items and services are related to the treatment of a similar condition.

229 (f) In carrying out subsection (e), in the case of items and services which are included by  
230 a provider or facility as part of a bundled payment, such items and services included in such  
231 bundled payment may be part of a single determination under this section.

232 (g) Entities shall be certified for participation in the IDR process in accordance with  
233 Section 2799A–1 (c)(4) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et  
234 seq.).

235 (h) Selection of a certified IDR entity shall be done jointly by the parties to the IDR  
236 process in conformance with the process established under Section 2799A–1 (c)(4)(F) of Title  
237 XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.).

238 (i) Not later than 30 days after the date of selection of the certified IDR entity with  
239 respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

240 (1) taking into account the considerations specified in subsection (k), select one of the  
241 offers submitted under subsection (j) to be the amount of payment for such item or service  
242 determined under this section, as applicable; and

243 (2) notify the parties to such determination of the offer selected under subsection (i)(1).

244 (j) Not later than 10 days after the date of selection of the certified IDR entity with  
245 respect to a determination for a qualified IDR item or service, the provider or facility and the  
246 carrier party to such determination—

247 (1) shall each submit to the certified IDR entity with respect to such determination—

248 (A) an offer for a payment amount for such item or service furnished by such provider or  
249 facility; and

250 (B) such information as requested by the certified IDR entity relating to such offer; and

251 (2) may each submit to the certified IDR entity with respect to such determination any  
252 information relating to such offer submitted by either party, including information relating to any  
253 circumstance described in subsection (k).

254 (k) In determining which offer is the payment to be applied pursuant to this section, the  
255 certified IDR entity, with respect to the determination for a qualified IDR item or service shall  
256 consider—

257 (1) the qualifying payment amounts for the applicable year for items or services that are  
258 comparable to the qualified IDR item or service and that are furnished in the same geographic  
259 region as such qualified IDR item or service; and

260 (2) subject to subsection (m), information on any circumstance described in subsection  
261 (l), such information as requested in subsection (j)(1)(B), and any additional information  
262 provided in subsection (j)(2).

263 (1) For purposes of this subsection, the circumstances described in this subsection are,  
264 with respect to a qualified IDR item or service of an out-of-network provider or carrier the  
265 following:

266 (1) The level of training, experience, and quality and outcomes measurements of the  
267 provider or facility that furnished such item or service (such as those endorsed by the consensus-  
268 based entity authorized in section 1890 of the Social Security Act).

269 (2) The market share held by the nonparticipating provider or facility or that of the plan  
270 or issuer in the geographic region in which the item or service was provided.

271 (3) The acuity of the individual receiving such item or service or the complexity of  
272 furnishing such item or service to such individual.

273 (4) The teaching status, case mix, and scope of services of the nonparticipating facility  
274 that furnished such item or service.

275 (5) Demonstrations of good faith efforts (or lack of good faith efforts) made by the  
276 nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network  
277 agreements and, if applicable, contracted rates between the provider or facility, as applicable,  
278 and the plan or issuer, as applicable, during the previous 4 plan years.

279 (m) In determining which offer is the payment to be applied with respect to qualified IDR  
280 items and services furnished by a provider or facility, the certified IDR entity with respect to a  
281 determination shall not consider usual and customary charges, the amount that would have been  
282 billed by such provider or facility with respect to such items and services had the provisions of  
283 this section (as applicable) not applied, or the payment or reimbursement rate for such items and

284 services furnished by such provider or facility payable by a public payor, including under the  
285 Medicare program under title XVIII of the Social Security Act, under the Medicaid program  
286 under title XIX of such Act, under the Children’s Health Insurance Program under title XXI of  
287 such Act, under the TRICARE program under chapter 55 of title 10, United States Code, or  
288 under chapter 17 of title 38, United States Code.

289 (n) A determination of a certified IDR entity under subsection (i)—

290 (1) shall be binding upon the parties involved, in the absence of a fraudulent claim or  
291 evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim;  
292 and

293 (2) shall not be subject to judicial review, except in a case where:

294 (A) the determination was procured by corruption, fraud, or undue means;

295 (B) there was evident partiality or corruption in the IDR entity;

296 (C) the IDR entity was guilty of misconduct in refusing to postpone the hearing, upon  
297 sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy;  
298 or of any other misbehavior by which the rights of any party have been prejudiced; or

299 (D) the IDR entity exceeded its powers, or so imperfectly executed them that a mutual,  
300 final, and definite award upon the subject matter submitted was not made.

301 (o) If an IDR entity makes a determination with respect to such notification under  
302 subsection (b), the party whose offer is not chosen under such subparagraph shall be responsible  
303 for paying all fees charged by such entity; and if the parties reach a settlement with respect to



304 such notification prior to such a determination, each party shall pay half of all fees charged by  
305 such entity, unless the parties otherwise agree.

306 (p) The total plan or coverage payment required pursuant to this section, with respect to a  
307 qualified IDR item or service for which a determination is made under subsection (i) or with  
308 respect to an item or service for which a payment amount is determined under open negotiations  
309 under subsection (a), shall be made directly to the out-of-network provider not later than 15 days  
310 after the date on which such determination is made.

311 Section 31. (a) Subject to subsection (b), in the case of a participant, beneficiary, or  
312 enrollee with benefits under a group health plan or group or individual health insurance coverage  
313 offered by a Carrier and who is furnished during a plan year beginning on or after January 1,  
314 2022, items or services (other than emergency services to which Section 1 applies) for which  
315 benefits are provided under the plan or coverage at a network facility by an out-of-network  
316 provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or  
317 enrollee for a payment amount for such an item or service furnished by such provider with  
318 respect to a visit at such facility that is more than the in-network cost-sharing amount for such  
319 item or service.

320 (b) Subsection (a) shall not apply with respect to items or services (other than ancillary  
321 services described in subsection (c)) furnished by an out-of-network provider to a participant,  
322 beneficiary, or enrollee of a group health plan or group or individual health insurance coverage  
323 offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of  
324 subsection (f).

325 (c) For purposes of subsection (b), ancillary services described in this subsection are,  
326 with respect to an in-network facility—

327 (1) subject to subsection (d), items and services related to emergency medicine,  
328 anesthesiology, pathology, radiology, and neonatology, and items and services provided by  
329 assistant surgeons, hospitalists, and intensivists;

330 (2) subject to subsection (d), diagnostic services (including radiology and laboratory  
331 services);

332 (3) items and services provided by such other specialty practitioners, as specified through  
333 rulemaking established under Section 2799B–2 of Title XXVII of the Public Health Service Act  
334 (42 U.S.C. 300gg et seq.); and

335 (4) items and services provided by an out-of-network provider if there is no in-network  
336 provider who can furnish such item or service at such facility.

337 (d) As established under Section 2799B–2 of Title XXVII of the Public Health Service  
338 Act (42 U.S.C. 300gg et seq.) certain advanced diagnostic laboratory tests shall not be included  
339 as an ancillary service described in subsection (c) and with respect to which subsection (a) would  
340 apply.

341 (e) In the case of an out-of-network provider or facility, who satisfies the notice and  
342 consent criteria of subsection (f) with respect to an item or service (referred to in this subsection  
343 as a ‘covered item or service’), such notice and consent criteria may not be construed as applying  
344 with respect to any item or service that is furnished as a result of unforeseen, urgent medical  
345 needs that arise at the time such covered item or service is furnished. For purposes of the

346 previous sentence, a covered item or service shall not include an ancillary service described in  
347 subsection (c).

348 (f) An out-of-network provider or facility satisfies the notice and consent criteria of this  
349 subsection, with respect to items or services furnished by the provider or facility to a participant,  
350 beneficiary, or enrollee of a group health plan or group or individual health insurance coverage  
351 offered by a health insurance issuer, if the provider (or, if applicable, the participating health care  
352 facility on behalf of such provider) or facility—

353 (1) in the case that the participant, beneficiary, or enrollee makes an appointment to be  
354 furnished such items or services at least 7 days prior to the date on which the individual is to be  
355 furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an  
356 authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior  
357 to the date on which the individual is furnished such items or services (or, in the case that the  
358 participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such  
359 items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an  
360 authorized representative of the participant, beneficiary, or enrollee) on such date the  
361 appointment is made), a written notice in paper or electronic form, as selected by the participant,  
362 beneficiary, or enrollee, (and including electronic notification, as practicable) that—

363 (A) contains the information required under subsection (g);

364 (B) clearly states that consent to receive such items and services from such  
365 nonparticipating provider or nonparticipating facility is optional and that the participant,  
366 beneficiary, or enrollee may instead seek care from a participating provider or at a participating  
367 facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing

368 responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility  
369 that would apply with respect to such an item or service that is furnished by a participating  
370 provider or participating facility, as applicable with respect to such plan; and

371 (C) is available in the 15 most common languages in the geographic region of the  
372 applicable facility;

373 (2) obtains from the participant, beneficiary, or enrollee (or from such an authorized  
374 representative) the consent described in subsection (h) to be treated by a nonparticipating  
375 provider or nonparticipating facility; and

376 (3) provides a signed copy of such consent to the participant, beneficiary, or enrollee  
377 through mail or email (as selected by the participant, beneficiary, or enrollee).

378 (g) For purposes of subsection (f)(1)(A), the information described in this subsection,  
379 with respect to an out-of-network provider or facility and a participant, beneficiary, or enrollee of  
380 a group health plan or group or individual health insurance coverage offered by a health  
381 insurance issuer, is each of the following:

382 (1) Notification, as applicable, that the health care provider is an out-of-network provider  
383 with respect to the health plan or the health care facility is out-of-network with respect to the  
384 health plan.

385 (2) Notification of the good faith estimated amount that such provider or facility may  
386 charge the participant, beneficiary, or enrollee for such items and services involved, including a  
387 notification that the provision of such estimate or consent to be treated under subsection (h) does  
388 not constitute a contract with respect to the charges estimated for such items and services.

389 (3) In the case of an in-network facility and an out-of-network provider, a list of any in-  
390 network providers at the facility who are able to furnish such items and services involved and  
391 notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a  
392 participating provider.

393 (4) Information about whether prior authorization or other care management limitations  
394 may be required in advance of receiving such items or services at the facility.

395 (h) For purposes of subsection (f)(2), the consent described in this paragraph, with  
396 respect to a participant, beneficiary, or enrollee of a group health plan or group or individual  
397 health insurance coverage offered by a health insurance issuer who is to be furnished items or  
398 services by an out-of-network provider or facility, is a document specified under Section 2799B-  
399 2 (d)(3) of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) that shall be  
400 signed by the participant, beneficiary, or enrollee before such items or services are furnished and  
401 that —

402 (1) acknowledges (in clear and understandable language) that the participant, beneficiary,  
403 or enrollee has been—

404 (A) provided with the written notice under paragraph (f)(1);

405 (B) informed that the payment of such charge by the participant, beneficiary, or enrollee  
406 may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing,  
407 including an explanation that such payment may not apply to an in-network deductible applied  
408 under the plan or coverage; and

409 (C) provided the opportunity to receive the written notice under paragraph (f)(1) in the  
410 form selected by the participant, beneficiary or enrollee; and

411 (2) documents the date on which the participant, beneficiary, or enrollee received the  
412 written notice under paragraph (f)(1) and the date on which the individual signed such consent to  
413 be furnished such items or services by such provider or facility.

414 (i) The consent described in subsection (h), with respect to a participant, beneficiary, or  
415 enrollee of a group health plan or group or individual health insurance coverage offered by a  
416 health insurance issuer, shall constitute only consent to the receipt of the information provided  
417 pursuant to this subsection and shall not constitute a contractual agreement of the participant,  
418 beneficiary, or enrollee to any estimated charge or amount included in such information.

419 Section 32. (a) A Carrier offering a plan(s) that includes a Network(s) shall maintain such  
420 Network(s) such that it is adequate in numbers and types of Providers to assure that all covered  
421 services will be accessible to all Insureds without unreasonable delay. Adequacy shall be  
422 determined through consideration of whether the Network includes a sufficient number of  
423 contracted providers of emergency services and surgical or ancillary services at or for the  
424 Carrier's contracted in-network hospitals to reasonably ensure that enrollees have in-network  
425 access to covered benefits delivered at that facility.

426 (b) The Commissioner shall adopt rules for a health carrier's network adequacy. Such  
427 rules shall establish, but not be limited to:

428 (1) waiting times for appointments for non-emergency care;

429 (2) choice of and access to providers for specialty care, specifically addressing the needs  
430 of the chronically ill, mentally ill, persons with substance use disorder, developmentally disabled  
431 or those with a life-threatening illness;

432 (3) standards for geographic accessibility, which shall include standards for access to the  
433 provision of durable medical equipment requiring a prescription. However, such standards shall  
434 not restrict an insurer's ability to provide prescriptions for durable medical equipment that are  
435 shipped to the patient by postal service or other common or private carrier, and shall not apply to  
436 durable medical equipment devices used exclusively for the administration of medication;

437 (4) hours of operation for the carrier, including any entities performing prior approval or  
438 pre-authorization functions; and

439 (5) standards for addressing in-network access to hospital-based surgical and ancillary  
440 service providers, such as anesthesiologists, radiologists, pathologists, and emergency medicine  
441 physicians.

442 (c) Carriers shall maintain a Network of providers that includes but is not limited to  
443 Providers that specialize in mental health and substance abuse services, facility-based physicians,  
444 and providers that are essential community providers.

445 SECTION 7. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby  
446 amended by striking out clauses 14 and 15 and inserting in place thereof the following:-

447 (14) the toll-free telephone number, facsimile number, and internet site for the office of  
448 patient protection or, if applicable, the designated state consumer assistance program;

449 (15) a statement identifying whether the health benefit plan is subject to state law or the  
450 Employee Retirement Income Security Act; and  
451 (16) such other information as the commissioner may by regulation require.