

HOUSE No. 2167

The Commonwealth of Massachusetts

PRESENTED BY:

Michael J. Finn

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 improve health care costs for employers and consumers.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Michael J. Finn</i>	<i>6th Hampden</i>
<i>Jose F. Tosado</i>	<i>9th Hampden</i>
<i>Brian M. Ashe</i>	<i>2nd Hampden</i>
<i>Gerard Cassidy</i>	<i>9th Plymouth</i>

HOUSE No. 2167

By Mr. Finn of West Springfield, a petition (accompanied by bill, House, No. 2167) of Michael J. Finn and others relative to alternative payment methods by health insurers. Financial Services.

The Commonwealth of Massachusetts

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

An Act to improve health care costs for employers and consumers.

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

1 SECTION 1. Chapter 176O is hereby amended by adding after section 27 thereof the
2 following section:-

3 Section 28.

4 As used in this section, the following words shall have the following meanings:

5 “Alternative Payment Methods”: Models of payment for health care services, as agreed to
6 by a Carrier and a Health Care Provider that incorporate various degrees of risk sharing and
7 reimburse the Health Care Provider for the provision and coordination of care for a range of
8 covered services and may include prospective payments, blended capitated payments, shared
9 savings, or other payment methods that promote improved coordination of care, higher quality, a
10 reduction in inappropriate utilization, and lower costs.

11 “Health Care Providers” physicians licensed under the provisions of chapter one hundred
12 and twelve, physician group practices, or a hospital licensed under the provisions of chapter one

13 hundred and eleven and its agents and employees, or a public hospital and its agents and
14 employees.

15 (a) Every health care provider which provides covered services to a person must provide
16 such services to any such person as a condition of their licensure, and must accept payment by a
17 carrier consistent with the provisions of this section, and may not balance bill such person for
18 any amount in excess of the amount paid by the carrier pursuant to this section, other than
19 applicable co-payments, co-insurance and deductibles. Any health care provider that participates
20 in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's
21 network due to the carrier's compliance with this section.

22 (b) No carrier or health care provider shall enter or renew a contract or agreement on or
23 after January 1, 2019, subject to the timeframes stated in (d) below), under which the carrier
24 agrees to pay the health care provider at a rate that is not in conformity with the standards as
25 forth in subsection (d).

26 (c) Carriers shall, utilizing claims-paid data, as filed annually to the Center for Health
27 Information and Analysis, calculate the carrier-specific relative prices the carrier has agreed to
28 pay health care providers determined using the provider categories and uniform methodology for
29 price relativities established by the Center for Health Information and Analysis pursuant to
30 section 10 of Chapter 12C, and identified on a state-wide basis and by provider type.

31 (d) No carrier or health care provider shall enter or renew a contract or agreement on or
32 after January 1, 2019 under which the health care provider is reimbursed at a rate that is above
33 the carrier-specific 80th percentile of health care provider relative price within each of the
34 applicable 4 geographic regions, as defined below. Provided, however, that if the health care

35 provider is above the 90th percentile of health care provider relative price within each of the
36 applicable 4 geographic regions on the effective date of this section, the carrier and provider
37 shall have 5 years from the effective date of this section to achieve the 80th percentile target, and
38 if the health care provider is above the 85th percentile of health care provider relative price
39 within each of the applicable 4 geographic regions on the effective date of this section, the
40 carrier and provider shall have 2 years from the effective date of this section to achieve the 80th
41 percentile target:

42 Region A (Western MA, 010 through 013)

43 Region B (Central MA, 014 through 016) and (Metro West, 017 and 020)

44 Region D (Merrimack, 018 through 019) and (Boston, 021 through 022 and 024)

45 Region F (South Eastern MA, 023 and 027), (Cape, 025 through 026)

46 (e) For contracts entered into prior to the effective date of this act, the provisions shall
47 take effect upon the anniversary date of the contract.

48

49 (f) Any net savings realized by the Carrier attributable to the operation of this section shall
50 be reflected in the premiums charged to health plan eligible members.

51

52 (g) Every health care provider that does not agree to participate in a carrier's network
53 must accept a rate equal to the carrier-specific median relative price within the applicable
54 geographic region, as defined in subsection (d) for any covered out-of-network charges.

55

56 Nothing in this subsection shall prohibit a carrier from denying payment for unapproved
57 services conducted by a non-network provider. Every out-of-network health care provider must
58 accept payment by a carrier consistent with the provisions of this section, and may not balance
59 bill such person for any amount in excess of the amount paid by the carrier pursuant to this
60 section for such covered out-of-network services, other than applicable co-payments, co-
61 insurance and deductibles.

62

63 In any given year there shall be no net increase in premiums due to the operation of this
64 section. The Commissioner may promulgate regulations to monitor and ensure compliance with
65 this section 28.

66

67 SECTION 2. Chapter 93A of the General Laws is hereby amended by adding the
68 following section:

69

70 Section 12. A health care provider, as defined in section 1 of chapter 176O, shall not
71 recoup or attempt to recoup amounts in excess of the amounts charged to carriers pursuant to
72 section 28 of chapter 176O by increasing charges to other health benefit plans or other payers.
73 The attorney general may adopt regulations enforcing this section, which shall include
74 requirements for identifying and enforcing noncompliance and penalties for noncompliance.

75

76 SECTION 3. Chapter 12C of the General Laws is hereby amended by after section 23
77 inserting the following new section:

78 Section 24 Health Care Provider Exemption

79 (a) Upon application by a health care provider, the executive director, in consultation
80 with the commissioner of the division of insurance, shall annually determine whether a health
81 care provider may receive an exemption from the provision of Section 28 of Chapter 176O. The
82 executive director shall weigh the criteria presented by the health care provider against any
83 potential for such exemption to raise health care premiums. Special consideration shall be given
84 to the potential impact on health care premiums. The center shall consider the following criteria
85 for exemption:

86

87 Whether the health care provider provides certain unique and specialty services; and

88

89 The provider's geographic location; and

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91 Whether application of Section 28 of Chapter 176O would jeopardize the financial
92 solvency of the health care provider.

93

94 (b) All applications for an exemption to Section 28 of Chapter 176O shall be submitted to
95 the executive director no later than December 1 of each year. The executive director must hold a

96 public hearing within 15 days upon receipt of a health care provider's submission for exemption.
97 The executive director shall issue a written decision within 15 days after the conclusion of the
98 hearing. The attorney general may intervene in such hearings.

99

100 (c) The attorney general shall review and analyze any information submitted to the center
101 and may require any provider seeking an exemption to produce documents and testimony under
102 oath related to the circumstances warranting an exemption to Section 28 of Chapter 176O.

103

104 (d) Any hospital or physician group practice that is part of a system shall file for an
105 exemption independently from the parent or other organizations comprising the system.

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107 (f) The executive director may promulgate regulations to enforce the provisions of this
108 section.

109

110 SECTION 4. The division of insurance, in consultation with the Center for Health
111 Information and Analysis, shall conduct a study of the impact of section 28 of chapter 176O. The
112 study shall include, but not be limited to, an examination of the impact on carrier provider
113 networks, network adequacy, rates paid to non-participating providers, and the overall impact on
114 carrier member premiums. The division may conduct a public hearing and receive input from
115 interested parties. The division shall file a report with the clerks of the senate and house of

116 representatives not later than January 1, 2020 on its findings and may make recommendations for
117 legislation.

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119 SECTION 5. Section 28 of Chapter 176O is hereby repealed.

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121 SECTION 6. Section 24 of Chapter 12C is hereby repealed.

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123 SECTION 7. Sections 5 and 6 of this act shall take effect on December 31, 2023.