HOUSE DOCKET, NO. 2719 FILED ON: 1/17/2019

HOUSE . . . . . No. 931

The Commonwealth of Massachusetts

PRESENTED BY:

Gerard J. Cassidy

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 promoting high value and high quality care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Gerard J. Cassidy	*9th Plymouth*
Michael D. Brady	*Second Plymouth and Bristol*
Michelle M. DuBois	*10th Plymouth*

HOUSE DOCKET, NO. 2719 FILED ON: 1/17/2019

HOUSE . . . . . No. 931

By Mr. Cassidy of Brockton, a petition (accompanied by bill, House, No. 931) of Gerard J. Cassidy, Michael D. Brady and Michelle M. DuBois relative to the quality of healthcare and healthcare benefits and insurance. Financial Services.

The Commonwealth of Massachusetts

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

An Act promoting high value and high quality care.

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. Section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 32, the words " and (xi) " and inserting in place thereof the following words:- (xi) not less than 3 representatives of the pharmaceutical industry; (xii) at least 1 pharmacy benefit manager; and (xiii).

SECTION 2. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word "commission", in line 59, the first time it appears, the following words:- ; and (iii) in the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony concerning factors underlying prescription drug costs and price increases, the impact of manufacturer rebates, discounts and other price concessions on net pricing, the availability of alternative drugs or treatments and any other matters as determined by the commission.

SECTION 3. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:- The report shall be based on the commission's analysis of information provided at the hearings by providers, provider organizations, insurers, pharmaceutical manufacturing companies and pharmacy benefit managers, registration data collected under section 11, data collected or analyzed by the center under sections 8, 9, 10 and 10A of chapter 12C and any other available information that the commission considers necessary to fulfill its duties under this section as defined in regulations promulgated by the commission.

SECTION 4. Chapter 6D of the General Laws is hereby further amended by inserting after section 15 the following 2 sections:-

Section 15A. (a) The commission shall develop, implement and promote an evidence-based outreach and education program to support the therapeutic and cost-effective utilization of prescription drugs for physicians, podiatrists, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs. In developing the program, the commission shall consult with physicians, podiatrists, pharmacists, nurses, private insurers, hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the University of Massachusetts medical school.

(b) The program shall arrange for physicians, podiatrists, pharmacists and nurses to conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing methods from behavioral science, educational theory and, where appropriate, pharmaceutical industry data and outreach techniques; provided, however, that, to the extent possible, the program shall inform prescribers about drug marketing that is intended to circumvent

competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options.

The program shall be designed to provide outreach to: physicians, podiatrists and other health care practitioners who participate in MassHealth, the subsidized catastrophic prescription drug insurance program established in section 39 of chapter 19A, other publicly-funded, contracted or subsidized health care programs, academic medical centers and other prescribers.

The commission shall, to the extent possible, utilize or incorporate into its program other independent educational resources or models proven effective in promoting high quality, evidenced-based, cost-effective information regarding the effectiveness and safety of prescription drugs including, but not limited to: (i) the Pennsylvania Pharmaceutical Assistance Contract for the Elderly Independent Drug Information Service affiliated with Harvard University; (ii) the Academic Detailing Program through the University of Vermont Larner College of Medicine's Office of Primary Care and Area Health Education Centers Program; (iii) the Drug Effectiveness Review Project coordinated by the Center for Evidence-based Policy at Oregon Health and Science University; and (iv) the North Carolina evidence-based peer-to-peer education program outreach program.

(c) The commission shall make an annual report, not later than March 1, 2019, on the operation of the program. The report shall be made publicly available on the commission's website and include information on the outreach and education components of the program, revenues, expenditures and balances and savings attributable to the program in health care programs funded by the commonwealth.

(d) The commission shall undertake a public education initiative to inform residents of the commonwealth about clinical trials and drug safety information.

(e) The commission may establish and collect fees for subscriptions and contracts with private health care payers related to this section. The commission may seek funding from nongovernmental health access foundations and undesignated drug litigation settlement funds associated with pharmaceutical marketing and pricing practices.

Section 15B. (a) The commission shall conduct an annual study of pharmaceutical manufacturing companies with pipeline drugs, generic drugs or biosimilar drug products that may have a significant impact on statewide health care expenditures; provided, however, that the commission may issue interim studies if it deems it necessary. The commission may contract with a third-party entity to implement this section.

(b) A pharmaceutical manufacturing company shall, provide early notice to the commission for: (i) a pipeline drug; (ii) an abbreviated new drug application for generic drugs, upon submission to the federal Food and Drug Administration; or (iii) a biosimilar biologics license application upon the receipt of an action date from the federal Food and Drug Administration. The commission shall make early notice information available to the office of Medicaid or another agency, as deemed appropriate.

Early notice shall be submitted to the commission not later than 60 days after receipt of the federal Food and Drug Administration action date or after the submission of an abbreviated new drug application to the federal Food and Drug Administration action.

For each prescription drug product, early notice shall include a brief description of the: (i) primary disease, health condition or therapeutic area being studied and the indication; (ii) route

of administration being studied; (iii) clinical trial comparators; and (iv) estimated year of market entry. To the extent possible, information shall be collected using data fields consistent with those used by the federal National Institutes of Health for clinical trials.

For each pipeline drug, early notice shall include whether the drug has been designated by the federal Food and Drug Administration: (i) orphan drug; (ii) fast track; (iii) breakthrough therapy; (iv) for accelerated approval; or (v) priority review for a new molecular entity.

Notwithstanding the foregoing, submissions for drugs in development that receive such a designation by the federal Food and Drug Administration for new molecular entities shall be provided as soon as practical upon receipt of the relevant designation.

(c) The commission shall assess pharmaceutical manufacturing companies for the implementation of this section in a similar manner to the annual registration fees and other assessments related to the annual marketing disclosure reports required under section 2A of chapter 111N.

(d) Notwithstanding any general or special law to the contrary, information provided under this section shall be protected as confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

SECTION 5. Section 1 of chapter 12C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of "Patient-centered medical home" the following 2 definitions:

"Pharmaceutical manufacturing company", an entity engaged in the production, preparation, propagation, conversion or processing of prescription drugs, directly or indirectly,

by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis or an entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that "Pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

"Pharmacy benefit manager", a person or entity that administers: (i) a prescription drug, prescription device or pharmacist services or (ii) a prescription drug and device and pharmacist services portion of a health benefit plan on behalf of a plan sponsor including, but not limited to, self-insured employers, insurance companies and labor unions; provided, however, that "Pharmacy benefit manager" shall include a health benefit plan that does not contract with a pharmacy benefit manager and administers its own: (a) prescription drug, prescription device or pharmacist services; or (b) prescription drug and device and pharmacist services portion, unless specifically exempted by the center.

SECTION 6. Section 5 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "payers", in line 11, the following words:- , pharmaceutical manufacturing companies, pharmacy benefit managers.

SECTION 7. Said section 5 of said chapter 12C, as so appearing, is hereby further amended by inserting after the word "organizations", in line 15, the following words:- , affected pharmaceutical manufacturing companies, affected pharmacy benefit managers.

SECTION 8. Section 7 of said chapter 12C, as so appearing, is hereby amended by adding the following paragraph:-

To the extent that the analysis of pharmaceutical manufacturing companies and pharmacy benefit managers pursuant to section 10A increases the expenses of the center, the estimated increase in the center's expenses shall be fully assessed to pharmaceutical manufacturing companies and pharmacy benefit managers in the same manner as the assessment under section 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and administers either its own: (i) prescription drug, prescription device or pharmacist services; or (ii) prescription drug and device and pharmacist services portion shall not be subject to additional assessment under this paragraph.

SECTION 9. Section 10 of said chapter 12C, as so appearing, 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 10. Said chapter 12C is hereby further amended by inserting after section 10 the following section: Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform analysis of information regarding pharmaceutical manufacturing companies and pharmacy benefit managers and that enable the center to analyze: (i) year-over-year wholesale acquisition cost changes; (ii) year-over-year trends in net expenditures; (iii) net expenditures on subsets of brand and generic pharmaceuticals identified by the center; (iv) research and development costs as a percentage of revenue, costs paid with public funds and costs paid by third parties, to the extent such costs are attributable to a specific product or set of products; (v) annual marketing and advertising costs, identifying costs for direct-to-consumer advertising; (vi) annual profits over the most recent 5-year period; (vii) information regarding trends of estimated aggregate drug rebates and other price reductions paid by a pharmaceutical manufacturing company in connection with utilization of all pharmaceutical drug products offered by the pharmaceutical manufacturing company; (viii) information regarding trends of estimated aggregate drug rebates and other price reductions paid by a pharmacy benefit manager in connection with utilization of all drugs offered through the pharmacy benefit manager; (ix) information regarding pharmacy benefit manager practices in passing drug rebates or other price reductions received by the pharmacy benefit manager to a private or public health care payer or to the consumer; (x) information regarding discount or free product vouchers that a retail

pharmacy provides to a consumer in connection with a pharmacy service, item or prescription transfer offer or to any discount, rebate, product voucher or other reduction in an individual's out-of-pocket expenses, including co-payments and deductibles under section 3 of chapter 175H; (xi) cost disparities between prices charged to purchasers in the commonwealth and purchasers outside of the United States and (xii) any other information deemed necessary by the center.

(b) The center shall require the submission of available data and other information from pharmaceutical manufacturing companies and pharmacy benefit managers including, but not limited to: (i) changes in wholesale acquisition costs for prescription drug products as identified by the center; (ii) aggregate, company-level and product-specific research and development to the extent attributable to a specific product or products and other relevant capital expenditures for the most recent year for which final audited data are available for prescription drug products as identified by the center; (iii) the price paid by the manufacturer to acquire the prescription drug product if not developed by the manufacturer; (iv) the 5-year history of any increases in the wholesale acquisition costs; (v) annual marketing and advertising expenditures apportioned by activities directed to consumers and prescribers for prescription drug products as identified by the center; and (vi) a description, suitable for public release, of factors that contributed to reported changes in wholesale acquisition costs for prescription drug products as identified by the center.

(c) Except as specifically provided otherwise by the center or under this chapter, data collected by the center pursuant to this section from pharmaceutical manufacturing companies and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section of chapter 4 or under chapter 66.

SECTION 11. Said chapter 12C is hereby further amended by striking out section 11, as appearing in the 2016 Official Edition, and inserting in place thereof the following section: Section 11. The center shall ensure the timely reporting of information required under sections 8, 9, 10 and 10A. The center shall notify payers, providers, provider organizations, pharmacy benefit managers and pharmaceutical manufacturing companies of any applicable reporting deadlines. The center shall notify, in writing, a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company that it has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice shall result in penalties. The center shall assess a penalty against a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph of up to $5,000 per week for each week of delay after the 2-week period following receipt of the written notice; provided, however, that the maximum annual penalty against a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company under this section shall be $200,000. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011.

The center shall notify the attorney general of any pharmaceutical manufacturing company or pharmacy benefit manager that fails to comply with this section for further action pursuant to section 11N of chapter 12 or any other law.

For the purposes of this section, the center may promulgate regulations to define "just cause".

SECTION 12. Chapter 12C of the General Laws is hereby further amended by striking out section 14, as so appearing, and inserting in place thereof the following section: Section 14. (a)(1) The center, in consultation with the statewide advisory committee established pursuant to subsection (c) shall, not later than March 1 in each even-numbered year, establish a standard set of measures of health care provider quality and health system performance, hereinafter referred to as the "standard quality measure set", for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, which incorporate quality measures into payment terms, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; and (iv) monitoring system-wide performance.

(2) The standard quality measure set shall be used by the commonwealth and carriers in contracts with health care providers to incorporate quality measures into the payment terms pursuant to section 30 of chapter 32A, section 80 of chapter 118E, section 108O of chapter 175, section 41 of chapter 176A, section 27 of chapter 176B, section 35 of chapter 176G, section 14 of chapter 176I and for assigning tiers to health care providers in tiered network plans pursuant to section 11 of chapter 176J.

(3) The standard quality measure set shall designate: (i) core measures that shall be used in contracts between payers, including the commonwealth and carriers, and health care providers, including provider organizations and accountable care organizations, that incorporate quality measures into payment terms, and shall meet the core criteria set by the Quality Measurement Alignment Task Force; and (ii) a menu of non-core measures that may be used in such contracts. The standard quality measure set shall allow for innovation and the development

of outcome measures. If the standard quality measure set established by the center differs from the recommendations of the statewide advisory committee, the center shall issue a written report detailing each area of disagreement and the rational for the center's decision.

(b) The center shall develop the uniform reporting of the standard quality measure set for each health care provider facility, medical group or provider group in the commonwealth.

(c)(1) The center shall convene a statewide advisory committee which shall make recommendations for the standard quality measure set to: (i) ensure consistency in the use of quality measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth; (ii) ensure consistency in methods for the assignment of tiers to providers in the design of any health plan; (iii) improve quality of care; (iv) improve transparency for consumers and employers; (v) improve health system monitoring and oversight by relevant state agencies; and (vi) reduce administrative burden.

(2) The statewide advisory committee shall consist of the secretary of health and human services and the executive director of the health policy commission, or their designees, who shall serve as co-chairs, and shall include the following members or their designees: executive director of the center; the executive director of the Betsy Lehman center for patient safety and medical error reduction; the executive director of the group insurance commission; the director of the Massachusetts e-Health Institute; the secretary of elder affairs; the assistant secretary for MassHealth; the commissioner of the department of public health; the commissioner of the department of mental health; and 11 members who shall be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.,

of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall a registered nurse licensed to practice in Massachusetts who practices in a patient care setting; 1 of whom shall be a representative of a labor organizations representing health care workers; 1 of whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of whom shall be a representative for consumers. Members appointed to the statewide advisory committee shall have experience with and expertise in health care quality measurement.

(3) The statewide advisory committee shall meet quarterly to develop recommendations for the core measure and non-core measures to be adopted in the standard quality measure set for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, which incorporate quality measures into payment terms, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; and (iv) monitoring system-wide performance.

(4) In developing its recommendations for the standard quality measure set, the statewide advisory committee shall incorporate nationally recognized quality measures including, but not limited to recommendations from the executive office of health and human services performance measurement alignment task force, measures used by the Centers for Medicare and Medicaid Services, the group insurance commission, carriers and providers and provider organizations in the commonwealth and other states, as well as other valid measures of health care provider

performance, outcomes, including patient-reported outcomes and functional status, patient experience, disparities and population health. The statewide advisory committee shall consider measures applicable to primary care providers, specialists, hospitals, provider organizations, accountable care organizations, oral health providers and other types of providers and measures applicable to different patient populations.

(5) The statewide advisory committee shall, not later than January 1 in each even-numbered year, submit to the center its recommendations on the core measures and non-core measures to be adopted, changed or updated by the center in the standard quality measure set, along with a report in support of its recommendations.

SECTION 13. Chapter 32A of the General Laws is hereby amended by adding at the end the following new section:

Section 28: Notwithstanding any general or special law or rule or regulation to the contrary, the Group Insurance Commission and any carrier, as defined in Section 1 of Chapter 176O of the general laws or other entity which contracts with the Commission to provide health benefits to eligible Employees and Retirees and their eligible dependents, shall provide coverage for health care services through the use of telemedicine by a contracted health care provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed on the same basis as the same service through in-person consultation or contact.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,

copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 14. Chapter 32B of the General Laws, as appearing in the 2014 official edition, is hereby amended by adding at the end the following new section:

Section 30: Notwithstanding any general or special law or rule or regulation to the contrary, the Group Insurance Commission and any carrier, as defined in Section 1 of Chapter 176O of the general laws or other entity which contracts to provide health benefits to eligible employees of the governmental unit and their eligible dependents, shall provide coverage for health care services through the use of telemedicine by a contracted health care provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed on the same basis as the same service through in-person consultation or contact.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not

be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient’s medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 15. Section 9 of chapter 94C of the General Laws, as so appearing, is hereby amended by striking the following words in lines 31-32 of paragraph (b):- “in a single dose or in a quantity” and;

By striking in line 35 the words, “essential for the treatment of a patient” and add the words, “which is for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice.” And;

By striking in lines 35-39 the words, “The amount or quantity of any controlled substance dispensed under this subsection shall not exceed the quantity of a controlled substance necessary for the immediate and proper treatment of the patient until it is possible for the patient to have a prescription filled by a pharmacy.”

And by striking in line 91-93 after of paragraph € the lines “and shall be except from the requirement that such dispensing be in a single dose or as necessary for immediate and proper treatment under subsection (b).

SECTION 16. Section 19 of said chapter 94C shall be amended by inserting in line 6 of paragraph (a) after the word “prescription” “or practitioner who dispenses the controlled substance.”

SECTION 17. Section 1 of chapter 111 is hereby amended by striking out the definition of “Medical peer review committee” or “committee”, and inserting in place thereof the following definition:-

“Medical peer review committee” or “committee”, a committee of health care providers, which functions to: (i) evaluate or improve the quality of health care rendered by providers of health care services; (ii) determine whether health care services were performed in compliance with the applicable standards of care; (iii) determine whether the costs of health care services were performed in compliance with the applicable standards of care; (iv) determine whether the cost of the health care services rendered were considered reasonable by the providers of health services in the area; (v) determine whether a health care provider’s actions call into question such health care provider’s fitness to provide health care services; or (vi) evaluate and assist health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise; provided further, that “medical peer review committee” shall also include: (i) a committee of a pharmacy society or association that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care; or (ii) a pharmacy peer review committee established by a person or entity that owns a licensed pharmacy or employs pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care.

SECTION 18. Said chapter 111 of the General Laws is hereby further amended by inserting at the end of section 204 the following:

(f) The provisions of this section shall apply to any committee formed by an individual health care provider, physician group practice, licensed health care facility or any combination thereof to perform the duties or functions of medical peer review as set forth in section one of this chapter, notwithstanding the fact that the formation of the committee is not required by law or regulation or that the individual, group or facility is not solely affiliated with a public hospital or licensed hospital or nursing home or health maintenance organization.

SECTION 19. Section 5C of Chapter 112 of the General Laws is hereby amended to read as follows:

Section 5C. Every insurer or risk management organization which provides professional liability insurance to a registered physician shall report to the board any claim or action for damages for personal injuries alleged to have been caused by error, omission, or negligence in the performance of such physician's professional services where such claim resulted in:

(a) A final judgment in any amount, provided, however, that payments made as part of a disclosure, apology and early offer program, shall not be construed to be reportable to or by the board against the physician, absent a determination of substandard care rendered on the part of said physician; or

(b) A settlement in any amount, provided, however, that payments made as part of a disclosure, apology and early offer program, shall not be construed to be reportable to or by the board against the physician, absent a determination of substandard care rendered on the part of said physician; or

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the board no later than thirty days following the occurrence of any event listed in paragraph (a), (b), or (c).

Such reports shall be in writing on a form prescribed by the board and shall contain the following information:

(a) the name, address, specialty coverage, and policy number of the physician against whom the claim is made; and

(b) name, address and age of the claimant or plaintiff; and

(c) nature and substance of the claim; and

(d) date when and place at which the claim arose; and

(e) the amounts paid, if any, and the date and manner of disposition, judgment, settlement, or otherwise; and

(f) the date and reason for final disposition, if no judgment or settlement; and

(g) such additional information as the board shall require. No insurer or its agents or employees shall be liable in any cause of action arising from reporting to the board as required in this section.

SECTION 20. Section 118E of the General Laws, as so appearing in the 2014 Official Edition, is hereby amended by inserting at the end thereof the following new section:

Section 13C½. Notwithstanding any general or special law or rule or regulation to the contrary, the Executive Office of Health and Human Services shall provide coverage under its Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral

health management firms and third party administrators under contract to a Medicaid managed care organization or the Medicaid primary care clinician plan for health care services provided through telemedicine by a contracted provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Such health care services shall be reimbursed on the same basis that Medicaid and other entities covered in this paragraph reimburse for in-person consultation or contact.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 21. Section 47BB of chapter 175 of the General Laws, as most recently added by Section 158 of Chapter 224 of the Acts of 2012, is hereby amended by striking subsections (a)-(d) and adding at the end of the existing paragraph the following new paragraph:

Notwithstanding any general or special law or rule or regulation to the contrary, an insurer shall provide for coverage for health care services under an individual, group, or general policy of accident and sickness insurance to an insured through the use of telemedicine by a

contracted health care provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery of the same contracted health care services.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 22. Chapter 176A of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting at the end thereof the following new section:

Section 38: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a subscriber and the corporation under an individual or group hospital service plan shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person

delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery of the same contracted health care services.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 23. Chapter 176B of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting at the end thereof the following new section:

Section 25: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a subscriber and the medical service corporation shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery of the same contracted health care services.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 24. Chapter 176G of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting at the end thereof the following new section:

Section 33: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a member and a carrier shall provide for coverage for health services to a subscriber through the use of telemedicine by a contracted health care provider. Such health services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery of the same contracted health care services.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible,

copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 25. Chapter 176I of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting at the end thereof the following new section:

Section 13: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a covered person and an organization shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. . Such health care services shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery. Furthermore, such health care services shall be reimbursed at a rate no less than the rate for in-person consultation or in-person delivery of the same contracted health care services.

A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where

telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of two-way audio-visual interaction or store-and-forward technology, defined as the transmission of a patient's medical information, such as digital images, documents, and pre-recorded video, from an originating site to the physician at the distant site for clinical evaluation.

SECTION 26. The General Laws are hereby amended by inserting after chapter 176O the following chapter: A new Chapter 176O1/2 is hereby inserted.

Section 1. Definitions

As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Clinician", a physician licensed under section 2 of chapter 112, or advance practice clinician, including but not limited to a physician assistant licensed pursuant to section 9F of chapter 112, and advanced practice nurses, including but not limited to certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and psychiatric clinical nurse specialists licensed pursuant to section 80B of chapter 112.

"Clinician's Allowed Amount", a Clinician's Usual and Customary Amount after the discount applied under a Clinician's contractual arrangement with an Insurance Carrier, if any, or the amount of the allowed benefit if the Clinician is Out of Network. The Clinician's Allowed Amount constitutes the Clinician's contractually adjusted total expected payment for a professional service if the Clinician has a contractual arrangement with an Insurance Carrier.

"Clinicians' Usual and Customary Charge", the charges routinely billed by Clinicians' for their professional services regardless of payer involved and before any discounts that are

applied pursuant to charity or indigent patient charge policies or Insurance Carrier contracting discounts. Absent other considerations, the Usual and Customary Charge constitutes the Clinician's total expected payment for a service.

"Emergency medical condition", a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U. S.C. section 1395dd(e)(1)(B).

"In Network Services", professional services provided to an Insured by Clinicians who have contracted with the Insurance Carrier that insures the Insured.

"Insurance Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that is not a health benefit plan, as defined in section 1 of chapter 176J.

"Insurance Carrier Insured Allowable", the benefit amount that the Carrier assigns for the service rendered by a Clinician who has not entered into a contractual arrangement with the Insurance Carrier that insures the Insured.

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under other provisions of chapter 176O.

"Insured Balance Bill", the amount of the Clinician's Usual and Customary Charge that remains after the Insurance Carrier determines the Insurance Carrier Out of Network benefit and Insured Cost Sharing amount.

"Insured Co-Insurance", the portion of the Clinician's charge for professional services that the Insured is financially responsible for paying directly to the Clinician who rendered the professional services pursuant to the terms of the contractual arrangement between the Insured and the Insurance Carrier.

"Insured Co-Payment", the amount that is the Insured's responsibility for professional services received from a Clinician, as dictated by the terms of the contractual arrangement between the Insured and the Insurance Carrier. A co-pay amount may be stated as a percentage or as a flat rate for services.

"Insured Cost Sharing", the combination of the Insured Deductible, Co-Insurance and Co-Payment or those amounts that are the responsibility of the Insured for a Clinician's professional services. Insured Cost Sharing for an Unavoidable Out of Network Services bill

shall be limited to the amount that the Insured would have paid the Clinician for In-Network services.

"Insured Deductible", the Insured's financial responsibility for the Clinician's charges that is applied to the Clinician's Usual and Customary charges before applying either co-insurance or co-payments.

"Mediation", the process to mediate disputes between an Insurance Carrier and Clinician that is conducted outside of a formal court process; provided, however, that mediation shall only be legally binding if the parties have mutually agreed to it in writing.

"Medicare Physician Fee Schedule", the fee schedule modified and published annually by the Centers for Medicare and Medicaid for professional services.

"Minimum Benefit Standard", the greatest of the following amounts: (i) the amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual and customary rate for such services, or (iii) the amount Medicare would reimburse for such services. As used in this subparagraph, "usual and customary rate" means the eightieth percentile of all charges for the 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 an independent benchmarking database maintained by a nonprofit organization specified by the Commissioner of the Division of Insurance. Such organization shall not be affiliated with any health carrier.

"Opt Out Services", Out of Network Clinician Services in an Inpatient Hospital or Outpatient Hospital where the Insured voluntarily selects in writing to receive services from an Out of Network Clinician and is offered an estimate of Out of Network Charges and consents in

writing to be treated by an Out of Network Clinician and be financially responsible for Out of Network Services. Opt Out Services shall not include emergency department services and any related on call services provided to an Insured whose care begins in an emergency department.

"Out of Network Services", a Clinician's professional services provided to an Insured where the Clinician is not contracted with both the Insured's Insurance Carrier and the Insured's health insurance product/plan offered by the Insured's Insurance Carrier.

"Self-Funded Health Benefits Plan" or "Self-Funded Plan", a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. s.1001 et seq.

"Unavoidable Out of Network bill", a bill for Out of Network Services received by an insured for services rendered by a Clinician, where such Out of Network Services were rendered by such out-of-network Clinician at an in-network facility, or during a service or procedure previously approved or authorized by the health carrier and the insured did not have the ability to control to select such services from an in-network Clinician. A bill for Out of Network Services received by an Insured to screen for, evaluate, diagnose and/or treat an emergency medical condition by an out-of-network Clinician at an in-network facility shall be deemed an "Unavoidable Out of Network bill". "Unavoidable Out of Network bill" does not include a bill for non-emergency services received by an insured when the insured voluntarily selects in writing an out of network Clinician prior to the provision of the service or when the insured has the ability and control to select an in-network Clinician prior to the provision of the service but declines to exercise that option.

Section 2. The Minimum Benefit Standard for Insured Services

(a) If Out of Network Services are provided to an Insured by a Clinician resulting in an Unavoidable Out of Network bill, such Clinician shall bill the Insured's Insurance Carrier directly and the Insurance Carrier shall pay the Clinician for the professional services as coded and billed by the Clinician;

(b) Insurance Carriers shall make payment directly to the Clinician for an Unavoidable Out of Network bill for covered services within 30 calendar days of the submission of claim by the Clinician;

(c) The Insurance Carrier shall adjudicate the Insured's claim for Out of Network Services that result in an Unavoidable Out of Network bill at the Insured's In-Network benefits levels and the Insured's Cost Sharing for Out of Network Services shall be limited to amount that the Insured would have paid the Clinician for In-Network services;

(d) Insured Deductible for Out of Network services that result in an Unavoidable Out of Network bill shall be applied by the Insurance Carrier to Insured's Deductible for in-network services;

(e) Insurance Carriers shall make payment directly to the clinician providing Out of Network Services that result in an Unavoidable Out of Network bill at an amount not less than the Minimum Benefit Standard.

(f) Clinicians shall be prohibited from submitting a claim or charges for an Insured Balance Bill for Unavoidable Out of Network services to the Insured, provided that the Minimum Benefit Standard has been paid to the Clinician by the Insurance Carrier and provided that the Insured has not Opted Out of these protections for non-emergency services pursuant to section 3 of this chapter;

(g) In the case of services provided to a member of a Self-Funded Plan that does not elect to be subject to the provisions of this section, the Clinician shall be permitted to bill the covered person in excess of the applicable deductible, copayment, or coinsurance amounts.

Section 3. Opt Out Services

(a) A Clinician shall be prohibited from Insured Balance Billing for Unavoidable Out of Network services, except in the case of Opt Out Services.

(b) If there is a dispute regarding the Involuntary Out of Network service payment or charges the Clinician may institute mediation pursuant to the provisions of this chapter.

Section 4. Mediation

(a) A Clinician may initiate the mediation process by providing written notice of the dispute to the Insurance Carrier and the entity that will determine the mediation process.

(b) Mediation resolution shall be within 30 days of the date the mediation request is received by the Insurance Carrier, and Division of Insurance or its designee shall determine the mediation process.

(c) A Clinician shall be permitted to bundle similar claims or claims presenting common issues of fact or law can be bundled together and adjudicated in one mediation process to promote speedy dispute resolutions.

(d) The mediation official may select from either party's proposal but shall not create his own reimbursement rate.

(e) The Medicare Physician Fee Schedule shall not be used as a reference point for mediation process as it is a statutory and regulated fee schedule subject to budgetary and policy limitations established by Congress and Center for Medicare and Medicaid Services.

Section 5. False or Misleading Statements in Insurance Carrier Information

An Insurance Carrier shall not state, communicate or include in written form false, misleading or confusing information in their explanation of benefits to Insureds regarding Clinician Usual and Customary Charges, Out of Network Balance Billing, or mediation disputes between Clinicians and Insurance Carriers.

Section 6. Enforcement for non-compliance by Insurance Carriers or Clinicians

(a) A Clinician shall be prohibited from submitting a claim or charges in violation of this chapter.

(b) A Clinician who engages in a pattern and practice of regularly sending or communicating Out of Network Balance Bills to an Insured in violation of these provisions, except for cases of excusable neglect, shall lose the right to file mediation demands under provisions of this chapter.

(c) An Insurance Carrier that is in violation of this chapter is subject to sanctions, penalties and other corrective actions by the Division of Insurance

Section 7. Disclosure

(a) An Insurance Carrier shall inform an Insured or the Insured's Clinician, as applicable, at the time the Insured or the Insured's Clinician requests a prospective or concurrent review: (1) the network status under the Insured's health benefit plan of the Clinician who will

be providing the health care service or course of treatment; and (2) an estimate of the amount the Insurance Carrier will pay such Clinician for such service or treatment pursuant to the Minimum Benefit Standard.

(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.

(c) At the time of scheduling an admission, procedure or service for an insured patient or prospective patient, a health care provider, upon request by a patient or prospective patient, shall (i) notify the patient or prospective patient of their right to request and obtain from the provider provide, 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; (ii) provide, 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; (iii) 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 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 emergency services provided to a patient.

(d) 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 verbally or in writing 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 O; and (iii) notify verbally or in writing 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 emergency services provided to a patient.

Section 8. Self-Funded Plans

(a) With respect to an entity providing or administering a Self-Funded Health Benefits Plan and its plan members, this Chapter shall only apply if the plan elects to be subject to the provisions of this Chapter. To elect to be subject to the provisions of this Chapter, the self-funded plan shall provide notice, on an annual basis, to the Division of Insurance, on a form and in a manner prescribed by the Division, attesting to the plan's participation and agreeing to be bound by the provisions of this Chapter. The self-funded plan shall amend the employee benefit plan, coverage policies, contracts and any other plan documents to reflect that the benefits of this section shall apply to the plan's members.

(b) An Insurance Carrier, and any other entity providing or administering a Self-Funded Health Benefits Plan that elects to be subject to this Chapter, shall issue a health insurance identification card to the primary insured under a health benefits plan. In a form and manner to be prescribed by the department, the card shall indicate whether the plan is insured or, in the case of self-funded plans that elect to be subject to this Chapter, whether the plan is self-funded and whether the plan elected to be subject to this act.

SECTION 27. The provisions of SECTIONS 13, 14, 20 – 25 shall be effective for all contracts which are entered into, renewed, or amended one year after the effective date of this Act