Budget Amendment ID: FY2018-S3-527-R1

Redraft EHS 527

Patient Protection and Empowerment

Messrs. Welch and Lesser moved that the proposed new text be amended by inserting after section 6 the following section:-

"SECTION 6A. Chapter 6D of the General Laws is hereby amended by inserting after section 16 the following section:-

Section 16A. (a) The commission shall, upon consideration of advice or any other pertinent evidence, recommend the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services to be in effect for a 5-year period for the purposes of section 28 of chapter 176O.

(b) In making its recommendation, the commission shall consider: (i) the impact of each rate on total health care expenditures; (ii) the impact of each rate on in-network participation by health care providers; and (iii) whether each rate is understandable and easily administrable by health care providers and carriers.

(c) The board shall submit notice of its recommendation to the joint committee on health care financing. Within 30 days after such filing, the joint committee may hold a public hearing on the board's proposed rates. The joint committee may report its findings to the general court, together with drafts of legislation necessary to implement those findings, and, in that report, the joint committee may include its recommendation on whether to affirm or reject the board's recommendation within 20 days after the public hearing and shall provide a copy of its findings and proposed legislation to the board. If the general court does not enact legislation with respect

to the board's recommended modification to the rates within 35 days after the public hearing, the board's recommendation shall take effect for the applicable 5-year period.

(d) Prior to recommending the rates, the commission shall hold a public hearing. The public hearing shall be based on such other pertinent information or data that may be available to the board. The hearing shall examine current rates paid for in- and out-of-network services and the impact of those rates on the operation of the health care delivery system and determine, based on the testimony, information and data, an appropriate noncontracted commercial rate for emergency services and noncontracted commercial rate for nonemergency services consistent with subsection (b). The commission shall provide public notice of the hearing at least 45 days prior to the date of the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing

(e) The commission shall thereafter conduct a review of the established rates in the fourth year of their operation and make changes to those rates consistent with this section to be effective for the next 5-year period."' And

by inserting after section 44 the following section:-

"SECTION 44A. Said chapter 111 is hereby further amended by striking out section 228, as appearing in the 2014 Official Edition, and inserting in place thereof the following section:-

“Section 228. (a) Prior to an admission, procedure or service and upon request by a patient or prospective patient, a health care provider shall, within 2 working days, disclose the allowed amount or charge for the admission, procedure or service, including the amount of any facility fees required. If a health care provider is unable to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount of any facility fees required.

(b) If a patient or prospective patient is covered by a health plan, a health care provider who participates as a network provider shall, at the time of scheduling a procedure or service: (i) give sufficient information regarding the proposed admission, procedure or service for the patient or prospective patient to make an informed decision about the costs associated with that admission, procedure or service based on information available to the provider at that time, including the amount of any facility fees required; and (ii) inform the patient or prospective patient that they should obtain additional information about any applicable out-of-pocket costs, pursuant to section 23 of chapter 176O. A health care provider may assist a patient or prospective patient in using the health plan's toll-free number and website pursuant to said section 23 of said chapter 176O.

(c) A health care provider referring a patient to another provider shall disclose: (i) if the referred provider is part of or represented by the same provider organization as defined in section 11 of chapter 6D; (ii) the network status of that referred provider based on information available to the provider at the time of the referral; and (iii) sufficient information about the referred provider for the patient to obtain additional information about that provider’s network status under their health plan and any applicable out-of-pocket costs for that referral pursuant to section 23 of

chapter 176O based on information available to the provider at that time. For the purposes of this section, "allowed amount", shall mean the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured.” And

by inserting after section 60 the following 4 sections:-

“SECTION 60A. Section 1 of chapter 176O of the General Laws, as so appearing , is hereby amended by inserting after the definition of “Incentive plan” the following definition:-

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

SECTION 60B. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following definitions:-

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

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

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

SECTION 60C. Section 23 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word “benefits”, in line 10, the following words:- and the network status of an identified health care provider.

SECTION 60D. Said chapter 176O is hereby further amended by adding the following section:-

Section 28. (a) A carrier shall reimburse a health care provider as follows:

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

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

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

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

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

(c) Nothing in this section shall require a carrier to pay for nonemergency health care services delivered to an insured when the insured had a reasonable opportunity to choose to have the service performed by a network provider participating in the insured's health benefit plan. Evidence that an insured had a reasonable opportunity to choose to have the service performed by a network provider shall include, but not be limited to, a written acknowledgement signed by the insured that was provided by the health care provider prior to the delivery of nonemergency health care services within a reasonable period of time that permits the insured to seek health care services from a participating provider in the insured's health benefit plan and submitted with any claim for reimbursement from the carrier.

(d) The division shall promulgate regulations necessary to implement the provisions of this section." ; and

by inserting after section 95 the following 3 sections:-

"SECTION 95A. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for nonemergency services under chapter 176O of the General Laws shall be not more than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database by a nonprofit organization specified by the division of insurance. Such organization shall not be affiliated with a health carrier.

SECTION 95B. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for emergency services shall be no greater than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a

benchmarking database by a nonprofit organization specified by the division of insurance. Such organization shall not be affiliated with any health carrier.

SECTION 95C. Notwithstanding any general or special law to the contrary, a facility that has obtained provider-based status from Medicare pursuant to the requirements of 42 C.F.R. §413.65 shall, upon obtaining that designation, notify members of their patient panel that: (i) the facility is now considered to be a hospital out-patient department of the main hospital provider; and (ii) the health care services delivered at the facility will also incur a facility fee due to that status. Any facility with that designation shall also post such notice in a conspicuous place in every room of the facility where a patient or prospective patient would have a meaningful opportunity to consider that information prior to receiving health care services from that facility."; and

by inserting after section 107 the following section:-

"SECTION 107A. Section 6A shall take effect on January 1, 2020."; and

by inserting after section 108 the following 3 sections:-

"SECTION 108A. Sections 95A and 95B shall take effect on July 1, 2018.

SECTION 108B. Sections 95A and 95B are hereby repealed.

SECTION 108C. Section 108B shall take effect on December 31, 2019."