

HOUSE No. 1077

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act Relative to Minimizing Unnecessary Health Care Costs by Streamlining Administrative Requirements..

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: The Division of Insurance, in consultation with the Executive Office of
2 Health and Human Services as well as an advisory group that shall consist of 1 representative of
3 each of the following agencies or organizations: the Office of Medicaid, the Massachusetts
4 Behavioral Health Partnership, the Massachusetts Medical Society, the Massachusetts Hospital
5 Association, the Massachusetts Association of Behavioral Health Systems, the Massachusetts
6 Association of Health Plans, and Blue Cross Blue Shield of Massachusetts, shall analyze and
7 recommend standardized forms and procedures that achieve the following goals:

8 Standardize and improve access to up-to-date eligibility and enrollment information,
9 benefits, coverage and cost sharing information by focusing on the following areas:

10 Develop a standardized framework and terminology within which all health plans would
11 be required to describe their plans, the benefits covered, the conditions for coverage, and the cost
12 sharing required (such as deductibles, co-payments, coinsurance, balance billing), including any
13 differences related to the use of in-network or out-of-network providers;

14 Develop uniform standards for providing timely information that includes the insured’s
15 basic identifying information, plan identification and contact information, plan type, covered
16 benefits, cost sharing requirements, and administrative requirements that are conditions for
17 coverage;

18 Develop a process whereby the insured and providers are able to determine a patient’s
19 out-of-pocket costs for specific planned care. This would include having the insurer develop a
20 web-based portal or other real-time means of determining cost sharing for specific services.

21 Simplify and standardize elements of the billing, claims processing, and adjudication
22 processes, including:

23 Establish common rules for claims involving coordination of benefits that will include
24 determining which insurer has primary responsibility when an individual is covered by two
25 health plans; requiring that the insurers with secondary responsibility accept the medical
26 necessity decisions of the primary insurer; and, requiring that insurers accept updated secondary
27 insurer information collected by providers at the time of service, rather than holding payment
28 until they have obtained the information independently.

29 Standardize the format and layout of Explanations of Benefits (EOBs) so that it contains
30 specific minimum information needed by the insured and the health care provider and allow each
31 to understand coverage for services.

32 Streamline and standardize collection and reporting of clinical information for quality
33 measures by adhering to common definitions for data elements and standard practices for data
34 collection and submission, including frequency of reporting. Insurers should only require

35 reporting of quality measures that are endorsed by the National Quality Forum and are adopted
36 by the Hospital Quality Alliance (HQA) or Ambulatory Quality Alliance (AQA).

37 Develop and update a common set of evidence-based clinical guidelines to help foster
38 cost-effective and high quality care that will remove the complexity with trying to understand
39 different guidelines for various payers.

40 Develop a standardized and uniform pre-authorization form and procedures for clinical
41 services, including but not limited to radiology management, to remove the use of different
42 forms by different payers.

43 SECTION 2: The Division of Insurance shall report its conclusions and
44 recommendations by July 1, 2010 to the joint committee on health care financing and the house
45 and senate committees on ways and means. The Division shall further implement regulations
46 based on the final recommendations no later than January 1, 2011. Any such regulations shall
47 not modify or supersede the carrier's payment policy. Any such regulations shall not preclude
48 the carrier from adjudicating a claim pursuant to its billing guidelines, payment policies or
49 provider contracts.