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HOUSE . . . . No. 905

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act relative to the electronic submission of claims..

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

1 SECTION 1. Section 108 of Chapter 175 of the General Laws, as appearing in the
2 Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof
3 the following:

4 4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or
5 provider under a policy of accident and sickness insurance which is delivered or issued for
6 delivery in the commonwealth, and which provides hospital expense, medical expense, surgical
7 expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished
8 by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not
9 made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment
10 or whatever further documentation is necessary for payment of said claim within the terms of the
11 policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay,
12 in addition to any benefits which inure to such claimant or provider, interest on such benefits,
13 which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the
14 rate of one and one-half percent per month, not to exceed eighteen percent per year. The

15 provisions of this paragraph relating to interest payments shall not apply to a claim which an
16 insurer is investigating because of suspected fraud. Beginning on January 1, 2006, the provisions
17 of this paragraph shall only apply to claims for reimbursement submitted
18 electronically.

19 SECTION 2. Section 110 of Chapter 175 of the General Laws, as appearing in the
20 Official Edition, is hereby amended by striking out subsection (G) and inserting in place thereof
21 the following:

22 (G) For purposes of this section the term ""notice of a claim" shall mean any notification
23 whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm,
24 association, or corporation asserting right to payment under a policy of insurance which
25 reasonably apprises the insurer of the existence of a claim.

26 Within fifteen days after an insurer's receipt of notice of claim by a claimant under a
27 general or blanket policy of accident and sickness insurance which is delivered or issued for
28 delivery in the commonwealth, and which provides hospital expense, medical expense, surgical
29 expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished
30 by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not
31 made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment
32 or whatever further documentation is necessary for payment of said claim within the terms of the
33 policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay,
34 in addition to any benefits which inure to such claimant or provider, interest on such benefits,
35 which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the
36 rate of one and one-half percent per month, not to exceed eighteen percent per year. The

37 provisions of this paragraph relating to interest payments shall not apply to a claim which an
38 insurer is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions
39 of this paragraph shall only apply to claims for reimbursement submitted electronically.

40 SECTION 3. Chapter 176G of the General Laws, as appearing in the Official Edition, is
41 hereby amended by striking out section 6 and inserting in place thereof the following:

42 Section 6. A health maintenance organization may enter into contractual arrangements
43 with any other person or company for the provision, to the health maintenance organization, of
44 health services, insurance, reinsurance and administrative, marketing, underwriting or other
45 services on a nondiscriminatory basis. A health maintenance organization shall not refuse to
46 contract with or compensate for covered services an otherwise eligible provider solely because
47 such provider has in good faith communicated with one or more of his current, former or
48 prospective patients regarding the provisions, terms or requirements of the organization's
49 products as they relate to the needs of such provider's patients.

50 No contract between a participating provider of health care services and a health
51 maintenance organization shall be issued or delivered in the commonwealth unless it contains a
52 provision requiring that within 45 days after the receipt by the organization of completed forms
53 for reimbursement to the provider of health care services, the health maintenance organization
54 shall (i) make payments for such services provided, (ii) notify the provider in writing of the
55 reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional
56 information or documentation is necessary to complete said forms for such reimbursement. If the
57 health maintenance organization fails to comply with this paragraph for any claims related to the
58 provision of health care services, said health maintenance organization shall pay, in addition to

59 any reimbursement for health care services provided, interest on such benefits, which shall
60 accrue beginning 45 days after the health maintenance organization's receipt of request for
61 reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The
62 provisions of this paragraph relating to interest payments shall not apply to a claim that the
63 health maintenance organization is investigating because of suspected fraud. Beginning on
64 January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement
65 submitted electronically.

66 SECTION 4. Chapter 176I of the General Laws, as appearing in the Official Edition, is
67 hereby amended by striking section 2 and inserting in place thereof the following:

68 Section 2. An organization may enter into a preferred provider arrangement with one or
69 more health care providers upon a determination by the commissioner that the organization and
70 the arrangement comply with the requirements of this chapter and the regulations hereunder. An
71 organization shall not condition its willingness to allow any health care provider to participate in
72 a preferred provider arrangement on such health care provider's agreeing to enter into other
73 contracts or arrangements with the organization that are not part of or related to such preferred
74 provider arrangements. An organization shall not refuse to contract with or compensate for
75 covered services an otherwise eligible participating or nonparticipating provider solely because
76 such provider has in good faith communicated with one or more of his current, former or
77 prospective patients regarding the provisions, terms or requirements of the organization's
78 products as they relate to the needs of such provider's patients.

79 An organization shall submit information concerning any proposed preferred provider
80 arrangements to the commissioner for approval in accordance with regulations promulgated by

81 the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty
82 A of the General Laws. Said information shall include at least the following: (a) a description of
83 the health services and any other benefits to which the covered person is entitled; (b) a
84 description of the locations where and the manner in which health services and other benefits
85 may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with
86 preferred providers; (e) a description of the rating methodology and rates. The arrangement shall
87 meet the following standards:

88 (a) Standards for maintaining quality health care, including satisfying any quality
89 assurance regulations promulgated by any state agency;

90 (b) Standards for controlling health care costs;

91 (c) Standards for assuring reasonable levels of access of health care services and an
92 adequate number and geographical distribution of preferred providers to render those services;

93 (d) Standards for assuring appropriate utilization of health care service; and

94 (e) Other standards deemed appropriate by the commissioner.

95 No organization may enter into a preferred provider arrangement with one or more health
96 care providers unless said written arrangement contains a provision requiring that within 45 days
97 after the receipt by the organization of completed forms for reimbursement to the health care
98 provider, the organization shall (i) make payments for the provision of such services, (ii) notify
99 the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in
100 writing of what additional information or documentation is necessary to complete said forms for
101 such reimbursement. If the organization fails to comply with the provisions of this paragraph for

102 any claims related to the provision of health care services, said organization shall pay, in addition

103 to any reimbursement for health care services provided, interest on such benefits, which shall

104 accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate

105 of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph

106 relating to interest payments shall not apply to a claim that the organization is investigating

107 because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall

108 only apply to claims for reimbursement submitted electronically.