HOUSE DOCKET, NO. 332 FILED ON: 1/9/2009

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Standards for controlling health care costs;

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

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

(e) Other standards deemed appropriate by the commissioner.

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

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