

HOUSE No. 847

The Commonwealth of Massachusetts

PRESENTED BY:

Michael J. Finn

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 relative to the electronic submission of claims.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Michael J. Finn</i>	<i>6th Hampden</i>	<i>1/13/2015</i>

HOUSE No. 847

By Mr. Finn of West Springfield, a petition (accompanied by bill, House, No. 847) of Michael J. Finn relative to the electronic submission of insurance claims. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Eighty-Ninth General Court
(2015-2016)**

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 2012
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, 2017, the provisions
17 of this paragraph shall only apply to claims for reimbursement submitted electronically.

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

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

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

36 provisions of this paragraph relating to interest payments shall not apply to a claim which an
37 insurer is investigating because of suspected fraud. Beginning on January 1, 2017, the provisions
38 of this paragraph shall only apply to claims for reimbursement submitted electronically.

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

41 Section 6. A health maintenance organization may enter into contractual arrangements
42 with any other person or company for the provision, to the health maintenance organization, of
43 health services, insurance, reinsurance and administrative, marketing, underwriting or other
44 services on a nondiscriminatory basis. A health maintenance organization shall not refuse to
45 contract with or compensate for covered services an otherwise eligible provider solely because
46 such provider has in good faith communicated with one or more of his current, former or
47 prospective patients regarding the provisions, terms or requirements of the organization's
48 products as they relate to the needs of such provider's patients. No contract between a
49 participating provider of health care services and a health maintenance organization shall be
50 issued or delivered in the commonwealth unless it contains a provision requiring that within 45
51 days after the receipt by the organization of completed forms for reimbursement to the provider
52 of health care services, the health maintenance organization shall (i) make payments for such
53 services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or
54 (iii) notify the provider in writing of what additional information or documentation is necessary
55 to complete said forms for such reimbursement. If the health maintenance organization fails to
56 comply with this paragraph for any claims related to the provision of health care services, said
57 health maintenance organization shall pay, in addition to any reimbursement for health care
58 services provided, interest on such benefits, which shall accrue beginning 45 days after the health

59 maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per
60 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest
61 payments shall not apply to a claim that the health maintenance organization is investigating
62 because of suspected fraud. No contract between a participating home health agency or a
63 participating licensed hospice agency and a health maintenance organization shall be issued or
64 delivered in the commonwealth that requires the participating home health agency or
65 participating licensed hospice agency to be accredited by the Joint Commission on Accreditation
66 of Healthcare Organizations or other national accrediting body if it is certified for participation in
67 the Medicare program, Title XVIII of the federal Social Security Act, 42 U.S.C. Sections 1395 et
68 seq. Beginning on January 1, 2017, the provisions of this paragraph shall only apply to claims for
69 reimbursement submitted electronically.

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

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

82 products as they relate to the needs of such provider's patients. A preferred provider arrangement
83 entered into between an organization and a home health agency or licensed hospice agency shall
84 not require the participating home health agency or participating licensed hospice agency to be
85 accredited by the Joint Commission on Accreditation of Healthcare Organizations or other
86 national accrediting body if the agency is certified for participation in the Medicare program,
87 Title XVIII of the federal Social Security Act, 42 U.S.C. Sections 1395 et seq.

88 An organization shall submit information concerning any proposed preferred provider
89 arrangements to the commissioner for approval in accordance with regulations promulgated by
90 the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty
91 A of the General Laws. Said information shall include at least the following: (a) a description of
92 the health services and any other benefits to which the covered person is entitled; (b) a
93 description of the locations where and the manner in which health services and other benefits
94 may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with
95 preferred providers; (e) a description of the rating methodology and rates. The arrangement shall
96 meet the following standards: (a) Standards for maintaining quality health care, including
97 satisfying any quality assurance regulations promulgated by any state agency; (b) Standards for
98 controlling health care costs; (c) Standards for assuring reasonable levels of access of health care
99 services and an adequate number and geographical distribution of preferred providers to render
100 those services; (d) Standards for assuring appropriate utilization of health care service; and (e)
101 Other standards deemed appropriate by the commissioner.

102 No organization may enter into a preferred provider arrangement with one or more health
103 care providers unless said written arrangement contains a provision requiring that within 45 days
104 after the receipt by the organization of completed forms for reimbursement to the health care

105 provider, the organization shall (i) make payments for the provision of such services, (ii) notify
106 the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in
107 writing of what additional information or documentation is necessary to complete said forms for
108 such reimbursement. If the organization fails to comply with the provisions of this paragraph for
109 any claims related to the provision of health care services, said organization shall pay, in addition
110 to any reimbursement for health care services provided, interest on such benefits, which shall
111 accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate
112 of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph
113 relating to interest payments shall not apply to a claim that the organization is investigating
114 because of suspected fraud. Beginning on January 1, 2017, the provisions of this paragraph shall
115 only apply to claims for reimbursement submitted electronically.