

SENATE No. 502

The Commonwealth of Massachusetts

PRESENTED BY:

Susan C. Fargo

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 administrative simplification in health insurance.

PETITION OF:

NAME:

Susan C. Fargo

DISTRICT/ADDRESS:

SENATE No. 502

By Ms. Fargo, a petition (accompanied by bill, Senate, No. 502) of Susan C. Fargo for legislation relative to fair and equitable managed care contracting standards. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. 541 OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to administrative simplification in health insurance.

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 38 of chapter 118E of the General Laws is hereby amended by
2 inserting at the end thereof of the following new paragraphs:-

3 Within 45 days after the receipt by the Division of completed forms for reimbursement to
4 a physician who participates in a medical service program established pursuant to this chapter the
5 Division shall (i) make payments for such services provided by the physician that are services
6 covered under such medical assistance program and for which claim is made, or (ii) fully notify
7 the provider in writing or by electronic means of any and all reason or reasons for nonpayment,
8 or (iii) notify the provider within 15 days in writing or by electronic means of all additional
9 information or documentation that is necessary to establish such physician’s entitlement to such
10 reimbursement. If the Division fails to comply with the provisions of this paragraph for any such
11 completed claim, the Division shall pay, in addition to any reimbursement for health care

12 services provided to which the physician is entitled, interest on any unpaid amount of such
13 benefits, which shall accrue beginning 45 days after the Division's receipt of request for
14 reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per
15 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest
16 payments shall not apply to a claim that the Division is investigating because of suspected fraud.

17 The division shall provide written guidelines to providers of medical services that
18 participate in a medical assistance program established pursuant to this chapter setting forth a
19 statement of its policies and procedures that is complete, detailed and specific with regard to
20 what such providers must include in claims for reimbursement in order to qualify as a completed
21 claim for reimbursement payment for which any such provider is entitled. Such guidelines shall
22 identify all of the data and documentation that is to accompany each claim for reimbursement
23 and shall identify all utilization review and other screening policies and procedures employed by
24 the division in reviewing such claims submitted by a provider of medical services.

25 The division shall reimburse to providers of medical services that participate in a medical
26 assistance program established pursuant to this chapter reasonable physician office practice
27 expenses related to physician processing of prior authorizations for medications and procedures
28 which require a decision or review by a physician or other licensed health professionals under
29 the providers supervision or liability coverage.

30 SECTION 2. Section 108, subsection 4(c) of chapter 175 of the General Laws is hereby
31 amended in the second sentence by striking out the words “forty five days” and inserting in place
32 thereof the following:- “fifteen days”.

33 SECTION 3. Section 108 of chapter 175 of the General Laws is hereby amended by
34 adding at the end thereof the following:

35 13. Notwithstanding any provision of any policy of insurance, a company shall reimburse
36 to providers of medical services reasonable physician office practice expenses related to
37 physician processing of prior authorizations for medications and procedures which require a
38 decision or review by a physician or other licensed health professionals under the providers
39 supervision or liability coverage.

40 SECTION 4. Section 110G of chapter 175 of the General Laws is hereby amended in the
41 second sentence of the second paragraph by striking the words “forty five days” and inserting in
42 place thereof the following:- “fifteen days,”

43 SECTION 5. Section 8 of chapter 176A of the General Laws is hereby amended in the
44 first sentence of clause (e) by striking the words “within forty five days,”

45 SECTION 6. Section 7 of chapter 176B of the General Laws is hereby amended in the
46 second sentence of the second paragraph by striking out the words “forty five days” and inserting
47 in place thereof the following:- “fifteen days,”

48 SECTION 7. Section 7 of chapter 176B of the General Laws is hereby further amended
49 by adding at the end thereof the following:-

50 Any agreement between a medical service corporation and a participating physician shall
51 include reimbursement for reasonable physician office practice expenses related to physician
52 processing of prior authorizations for medications and procedures which require a decision or

53 review by a physician or other licensed health professionals under the providers supervision or
54 liability coverage.

55 SECTION 8. Section 6 of chapter 176G is hereby amended in the first sentence of the
56 second paragraph by striking out the words “45 days” and inserting in place thereof the
57 following:- “fifteen days,”

58 SECTION 9. Section 6 of chapter 176G is hereby further amended by adding at the end
59 thereof the following:-

60 No contract between a participating provider of health care services and a health
61 maintenance organization shall be issued or delivered in the commonwealth unless it includes
62 reimbursement for reasonable physician office practice expenses related to physician processing
63 of prior authorizations for medications and procedures which require a decision or review by a
64 physician or other licensed health professionals under the providers supervision or liability
65 coverage.

66 SECTION 10. Section 2 of chapter 176I is hereby amended in the first sentence of the
67 third paragraph by striking the words “45 days” and inserting in place thereof the following:
68 “fifteen days,”

69 SECTION 11. Section 2 of chapter 176I is hereby further amended by adding at the end
70 thereof the following:-

71 No organization may enter into a preferred provider arrangement with one or more health
72 care providers unless said written arrangement contains a provision requiring reimbursement for
73 reasonable physician office practice expenses related to physician processing of prior

74 authorizations for medications and procedures which require a decision or review by a physician
75 or other licensed health professionals under the providers supervision or liability coverage.

76 SECTION 12. Section 1 of chapter 176O of the General Laws is hereby amended by
77 inserting after the definition of “concurrent review” the following:-

78 “contracting agent” , a covered entity engaged, for monetary or other consideration, in the
79 act of leasing, selling, transferring, aggregating, assigning or conveying, a physician or physician
80 panel to provide health care services to beneficiaries.

81 And further, by inserting after the definition of “covered benefit”, the following:-

82 “covered entity” includes, but is not limited to, any entity responsible for payment or
83 coordination of health care services, including but not limited to all entities that pay or
84 administer claims on behalf of other entities.

85 And further, by inserting after the definition of “participating provider”, the following:-

86 “payer”, a self-insured employer, health care service plan, insurer, or other entity that
87 assumes the risk for payment of claims or reimbursement for services provided by contracted
88 physicians.

89 SECTION 13. Subsection (b) of Section 10 of chapter 176O of the General Laws is
90 hereby amended by adding the following paragraphs:

91 (4) a requirement that physician group budgets be based on an accepted per member per
92 month cost determined y actuarial input from a collaboration of representatives including
93 physicians, business groups, employers, carriers and the Division of Insurance.

94 (5) a requirement that reinsurance amounts be determined according to an actuarial
95 standard estimate of catastrophic events in a provider unit.

96 (6) a requirement that carriers provide the physician or physician group with detailed
97 expense descriptions, including but not limited to member name, dates of service, primary care
98 and referring physician information, the physician and/or facility performing the services,
99 amount paid, and, where applicable, amount withheld. Physicians should also receive specific
100 information on the company's provider units and/or contracted physicians reconciliation process
101 so that the provider can review the information at least three months prior to the corporation's
102 declaring the provider unit above, under, or at budget, and provided further that that physicians
103 and physician entities have immediate access to initial claims reports when the claims requests
104 are received by the health insurance plan.

105 (7) a provision permitting the provider to refuse participation in one or more such other
106 plans at the time the contract is executed without affecting the provider's status as a member of
107 or for eligibility in the plan which is the subject of such contract or other plans."

108 (8) a prohibition against modification of the contract without the express, written consent
109 of all parties.

110 (9) a requirement that claims which may involve other carriers or future settlements,
111 including but not limited to auto accidents involving legal cases, be extracted from year end
112 budget and settlement information

113 (10) a prohibition against representatives of health insurance carriers from initiating
114 communication with members or their families regarding treatment options and code statuses
115 without a physicians knowledge or presence.

116 SECTION14. Section 10 of chapter 176O of the General Laws is hereby amended by
117 inserting after subsection (c) the following subsections:-

118 (d) (1) A contracting agent shall be registered with the Division of Insurance. Provided
119 further that all contracts between a physician and a contracting agent shall comply with all of the
120 following requirements:

121 (a) Contain within the contract itself all material terms consistent with the general laws.

122 (b) Clearly and in a separate section, name any payer eligible to claim a discounted rate.

123 1. Any payers seeking eligibility to claim a discounted rate, directly or indirectly,
124 subsequent to the original execution of the contract must be added to the contract through a
125 separate amendment to the contract that is signed by the physician.

126 2. Any amendment naming additional payers shall be presented to the physician for
127 signature ninety (90) days prior to any anticipated disclosure, lease, sale, transfer, aggregation,
128 assignment, or conveyance of the physician's discounted rate.

129 (c) Identify and highlight all amendments made to the contract.

130 (d) Contain a provision identifying the right of the physician to affirmatively opt in
131 and/or opt out of any agreements to lease, sell, transfer, aggregate, assign or convey a physician
132 panel and associated discounts without penalty, sanction, or retaliation of any kind.

133 (e) Contain provisions informing the physician of his or her contracting and payment
134 rights, as specified in this section and all other relevant provisions of the general laws.

135 (f) Contain a provision fully disclosing any access fee or other remuneration the
136 contracting agent may receive and the specific benefits and service the contracting agent will
137 provide.

138 (g) Contain a provision that requires the contracting agent to obligate any payer or
139 covered entity, through contract, to not further disclose, lease, sell, transfer, aggregate, assign or
140 convey the physician panel and associated discounts to any other payer or entity; and

141 (h) Contain a provision that requires upon the termination of the physician-contracting
142 agent contract, the contracting agent to notify each payer or covered entity that the payer or
143 covered entity, is no longer authorized to:

144 1. Access the physician's discounted rate; or

145 2. Disclose, lease, sell, transfer, aggregate, assign, or convey the physician's discounted
146 rate.

147 (2) A contracting agent that proposes to sell, lease, assign, transfer or convey a
148 physician's name, contracted rate or any other information must have a direct contract with the
149 physician.

150 (3) A contracting agent shall ensure through contract terms that all payers to which it has
151 leased, sold, transferred, aggregated, assigned or conveyed a physician panel and its associated
152 discounts comply with the underlying contract between the contracting agent and the physician
153 and pay the physician pursuant to the rates of payment and methodology set forth in the
154 underlying contract.

155 (4) A contracting agent shall not lease, sell, transfer, aggregate, assign or convey its
156 physician panel and associated discounts or any other contractual obligation to any entity that is
157 not a payer.

158 (5) The contract between the contacting agent and physician will neither authorize nor
159 require the physician to consent to the sale of his or her name and contracted rates for use with
160 more than a single product or line of business.

161 (6) The contract between the contracting agent and the physician will neither authorize
162 nor require the physician to consent to the sale of his or her name and contracted rate more than
163 once.

164 (7) After receiving information from a contracted physician that a payer to whom a
165 contracting agent has leased, sold, transferred, aggregated, assigned or conveyed its physician
166 panel and associated discounts is not complying with the terms of the underlying contract,
167 including, but not limited to, statutory requirements for timely and accurate payment of claims,
168 and the contracted physician has fulfilled the appeal or grievance process described in the
169 underlying agreement, if any, without satisfaction, the contracting agent shall, within 45 days, do
170 at least one of the following:

171 (a) Ensure the payer causes correct payment to be made to the physician.

172 (b) Ensure the payer otherwise complies with the terms of the underlying contract or
173 terminate the contracting agent's agreement with the payer.

174 (c) Assume direct responsibility for the payment of the claim in question by paying the
175 physician the amount owed under the contract and in the manner required by general laws.

176 (8) A contracting agent shall require those payers and covered entities that are by contract
177 eligible to claim a physician's contracted rates to cease claiming entitlement to those rates upon
178 termination of the underlying contract between the contracting agent and the physician or upon
179 termination of the physician's authorization for the payer to pay the contracted reimbursement
180 rate as permitted under the terms of the contract between the contracting agent and the physician.

181 (9) Any explanation of benefits and/or remittance advice issued in the Commonwealth
182 after the effective date of this act, in electronic or paper format, shall include the identity of the
183 entity authorized to have leased, sold, transferred, aggregated, assigned or conveyed the
184 physician's name and associated discount.

185 (10) After the effective date of this act, a payer, or any representative of the payer,
186 processing claims or claims payments, shall clearly identify, in electronic or paper format, on the
187 explanation of benefits and/or remittance advice, the entity assuming financial risk for services
188 and the identity of the contracting agent through which the payment rate and any discount are
189 claimed. A copy of the underlying contract must be provided to the physician upon request.

190 (11) After the effective date of this act, where the covered entity, contracting agent, or
191 payer issues member or subscriber identification cards, the cards shall, in a clear and legible
192 manner, identify any third-party entity, including any contracting agent, responsible for paying
193 claims and any third-party entity, including a contracting agent, whose contract with a payer
194 controls or otherwise affects reimbursement for claims filed pursuant to the subscriber contract.

195 (12) No payer, payer representative, administrator of claims payment, or other third party
196 acting on behalf of a payer shall be eligible to claim or otherwise proffer a physician's specific
197 contracted rate for services except to the extent that the rate is based on the contract that directly

198 controls payment for services provided to that patient and is reflected on the explanation of
199 benefits and/or remittance advice and on any patient identification card issued to the patient.

200 (13) Nothing in the contract between the contracting agent and the physician shall
201 supersede the provisions of this act.

202 (14) In coordination with relevant state law, no covered entity may retaliate against a
203 physician for exercising the right of action provided under this Act.

204 (15) The Division of Insurance shall adopt regulations as necessary for the
205 implementation and administration of this Act. Upon finding a contracting agent, insurer, or
206 other entity in violation of this Act, the Commissioner of Insurance may issue a cease and desist
207 order to prevent violation of this Act and shall issue fines and penalties of no less than \$1,000
208 per violation. The Division shall adopt an administrative remedy process for parties to pursue
209 their rights, including but not limited to the recoupment of payment lost, by a physician, due to
210 an unauthorized agreement to lease, sell, transfer, aggregate, assign or convey a physician panel
211 and associated discount arrangement in violation with this Act.

212 (16) Nothing in this Act prohibits or limits any claim or action for a claim that the
213 physician has against a covered entity or contracting agent. All applicable administrative fines
214 and penalties apply.

215 (17) If any provision of this Act is held by a court to be invalid, such invalidity shall not
216 affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby
217 declared severable.