HOUSE DOCKET, NO. FILED ON: 1/13/2009

HOUSE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

John D. Keenan

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 passage of the accompanying bill:

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

PETITION OF:

NAME:	DISTRICT/ADDRESS:
John D. Keenan	7th Essex
Robert M. Koczera	11th Bristol
William Lantigua	16th Essex

The Commonwealth of Massachusetts

In the Year Two Thousand and 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:

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

1. Standardize and improve access to up-to-date eligibility and enrollment information, benefits, coverage and cost sharing information by focusing on the following areas:
    a. Develop a standardized framework and terminology within which all health plans would be required to describe their plans, the benefits covered, the conditions for coverage, and the cost sharing required (such as deductibles, co-payments, coinsurance, balance billing), including any differences related to the use of in-network or out-of-network providers;
    b. Develop uniform standards for providing timely information that includes the insured's basic identifying information, plan identification and contact information, plan type, covered benefits, cost sharing requirements, and administrative requirements that are conditions for coverage;
    c. Develop a process whereby the insured and providers are able to determine a patient's out-of-pocket costs for specific planned care. This would include having the insurer develop a web-based portal or other real-time means of determining cost sharing for specific services.

2. Simplify and standardize elements of the billing, claims processing, and adjudication processes, including:
    a. Establish common rules for claims involving coordination of benefits that will include determining which insurer has primary responsibility when an individual is covered by two health plans; requiring that the insurers with secondary responsibility accept the medical necessity decisions of the primary insurer; and, requiring that insurers accept updated secondary insurer information collected by providers at the time of service, rather than holding payment until they have obtained the information independently.
    b. Standardize the format and layout of Explanations of Benefits (EOBs) so that it contains specific minimum information needed by the insured and the health care provider and allow each to understand coverage for services.
3. Streamline and standardize collection and reporting of clinical information for quality measures by adhering to common definitions for data elements and standard practices for data collection and submission, including frequency of reporting. Insurers should only require reporting of quality measures that are endorsed by the National Quality Forum and are adopted by the Hospital Quality Alliance (HQA) or Ambulatory Quality Alliance (AQA).
4. Develop and update a common set of evidence-based clinical guidelines to help foster cost-effective and high quality care that will remove the complexity with trying to understand different guidelines for various payers.
5. Develop a standardized and uniform pre-authorization form and procedures for clinical services, including but not limited to radiology management, to remove the use of different forms by different payers.

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