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

SENATE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Stephen J. Buoniconti

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 to Provide Prompt, Fair and Equitable Settlement of Claims for Health Care Services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Stephen J. Buoniconti	Hampden

The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

AN ACT TO PROVIDE PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE SERVICES.

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 24B of chapter 175 of the General Laws, as appearing in the 2006 official edition, is hereby amended by inserting after the first paragraph the following paragraphs:

A health care insurer, including any self-insured sickness, health, or welfare plan, under this section shall be required to pay for health care services ordered by a health care provider if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A claim for treatment for medically necessary services may not be denied if a health care provider follows the health care insurer's authorization procedures and receives authorization for a covered service for the policy holder or subscriber, unless the provider submitted information to the insurer with the willful intention to misinform the Insurer.

An insurer shall not deny payment for a claim for medically necessary covered services on the basis of an administrative or technical defect in the claim except in the case where the insurer has

a reasonable basis, supported by specific information available for review, that the claim for health care services rendered was submitted fraudulently. An insurer shall have no more than twelve months after the original payment was received by the provider to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a full or partial payment. An insurer shall not recoup payments more than ninety days after the original payment was received by a provider for services provided to a policy holder or subscriber that the insurer deems ineligible for coverage because the policyholder or subscriber was retroactively terminated or retroactively disenrolled for services, provided that the provider can document that it received verification of an individual's eligibility status following the specific administrative requirements of the insurer at the time service was provided. Claims may also not be recouped for utilization review purposes if the services were already deemed medically necessary or the manner in which the services were accessed or provided were previously approved by the insurer or its contractor.

An insurer which seeks to make an adjustment pursuant to this section shall provide the health care provider with written notice that explains in detail the reasons for the recoupment, identifies each previously paid claim for which a recoupment is sought, and provides the health care provider with thirty days to challenge the request for recoupment. Such written notice shall be made to the provider not less than thirty days prior to the seeking of a recoupment or the making of an adjustment.

If a claim is denied because the provider, due to an unintentional act of error or omission, obtained no or only partial authorization, the provider may appeal the denial and the Insurer must conduct and complete within thirty days of the provider's submitted appeal a retrospective

review of the medical necessity of the service. If the insurer determines that the service is medically necessary, the Insurer must reverse the denial and pay the claim. If the insurer determines that the service is not medically necessary, the insurer shall provide the provider with specific written clinical justification for the determination and a process for appealing the determination.

SECTION 2: The Commissioner of Insurance shall promulgate regulations to enforce the provisions this Act no later than ninety days after the effective date of the Act. Such regulations shall be effective for all contracts between health care insurers, so-called, and providers of health care services, so-called, which are entered into, renewed, or amended on or after the regulations effective date.