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LINDA RUTHARDT
Commissioner of Insurance

Bulletin No. 00-13

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts (BCBSMA), Health Maintenance Organizations

From: Linda Ruthardt, Commissioner of Insurance

Re: Certain New Requirements for Payment of Claims

Date: September 8, 2000

This bulletin is to inform carriers of certain provisions relative to the payment of claims as expressed within Chapter 141 of the Acts of 2000 (Chapter 141), which was signed into law on July 21, 2000. Chapter 141 directs changes to the delivery of managed care in Massachusetts and creates new oversight bureaus within existing state agencies. Chapter 141 also requires changes in claims payment practices for existing health care plans. This bulletin addresses only those claims payment provisions effective on July 21, 2000 that directly affect all health insurers.

Chapter 141 amends sections 108 and 110 of M.G.L. c. 175. The effect of these changes is to require commercial insurance carriers with coverage for other than an insured preferred provider plan to respond within 45 days of receipt of a notice of a claim for reimbursement.

Chapter 141 also amends the following sections of the insurance statutes: M.G.L. c. 176A, § 8; M.G.L. c. 176B, § 7; M.G.L. c. 176G, § 6; and M.G.L. c. 176I, § 2. The effect of these changes is to require commercial insurance carriers with insured preferred provider plans, BCBSMA, and HMOs to respond within 45 days of receipt of completed forms for reimbursement.

Within the 45 days following receipt of the appropriate documentation, carriers must either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If the carrier fails to comply, the carrier is required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the claim at the rate of 1.5 percent per month, not to exceed 18 percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

Carriers are advised to examine the full text of Chapter 141 for a complete review of its provisions and should modify provider and subscriber contracts accordingly. Additional bulletins and regulations are expected to be issued on the other requirements of Chapter 141. Questions about this bulletin should be directed to the Health Unit of the State Rating Bureau, Division of Insurance, (617) 521-7349, or faxed to (617) 521-7773.