HOUSE DOCKET, NO. 534 FILED ON: 1/25/2021

HOUSE . . . . . No. 1086

The Commonwealth of Massachusetts

PRESENTED BY:

Carole A. Fiola

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 uncollected co-pays, co-insurance and deductibles.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Carole A. Fiola	*6th Bristol*	*1/25/2021*
Paul A. Schmid, III	*8th Bristol*	*2/19/2021*
Steven S. Howitt	*4th Bristol*	*2/22/2021*
Brian W. Murray	*10th Worcester*	*2/22/2021*
David Allen Robertson	*19th Middlesex*	*2/25/2021*
Michael J. Soter	*8th Worcester*	*3/4/2021*

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By Ms. Fiola of Fall River, a petition (accompanied by bill, House, No. 1086) of Carole A. Fiola and others for legislation to require certain healthcare carriers to share accountability with providers for uncollectible patient obligations after insurance. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *976* OF 2019-2020.]

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act relative to uncollected co-pays, co-insurance and deductibles.

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. Chapter 176O of the General Laws, as appearing in the 2018 official edition, is hereby amended by adding the following new section:

Section 7A. Equitable Funding for Health Care Provider Bad Debt

(a) Notwithstanding any other provision of the general laws to the contrary, a carrier shall reimburse a health care provider no less than sixty-five percent (65%) of each co-payment, co-insurance and/or deductible amount due under an insured's health benefit plan which are unpaid after reasonable collection efforts have been made by the health care provider pursuant to subsection (c) of this section.

(b) As used in this section, the following words shall have the following meanings: a "co-payment" is defined as a fixed dollar amount that is owed by an insured as required under a health benefit plan for health care services provided and billed by a healthcare provider. A "co-insurance" is defined as a percentage of the allowed amount, after a co-payment, if any, that an insured must pay for covered services received under a health benefit plan for health care services provided and billed by a healthcare provider. A "deductible" is defined as a specific dollar amount that an insured must pay for covered services before the carrier's health benefit plan becomes obligated to pay for covered health care services provided and billed by a healthcare provider; such deductible does not include any portion of premiums paid by an insured.

(c) Reimbursement for uncollected co-payment, co-insurance and/or deductible amounts due (each a "claim") under an insured's health benefit plan for covered services rendered shall be deemed an uncollectible bad debt, and a health care provider may submit a request for reimbursement to the carrier under the following conditions:

(1) The claim must be derived from the wholly or partially uncollected co-payment, co-insurance and/or deductible amounts under an insured's health benefit plan;

(2) The reimbursement requested by the health care provider should be for a claim where the co-payment, co-insurance, or deductible amount was at least two hundred and fifty dollars ($250), and each claim reflected a unique covered service under the health benefit plan per insured;

(3) The health care provider must have made reasonable collection efforts for each claim filed for reimbursement under this section, such efforts including documentation that the claim

has remained partially or fully unpaid and is not subject to an on-going payment plan for more than one hundred twenty (120) days from the date the first bill was mailed, which may include such efforts as telephone calls, collection letters, or any other notification method that constitutes a genuine and continuous effort to contact the member, said documentation shall include the date and method of contact;

(4) On or before May 1 of each year, the health care provider shall submit an aggregate request for reimbursement representing all claims that meet the criteria under this section in the prior calendar year. The request for reimbursement shall include documentation of the attempt to collect on the claim(s), the name and identification number of the insured, the date of service, the unpaid co-payment, co-insurance, or deductible, the amount that was collected, if any, and the date and general method of contact with the insured. For the purposes of this section, an insured co-payment, co-insurance, and/or deductible amount due shall be determined based on the date that the service is rendered; provided further that a carrier shall not prohibit reimbursement if the insured is no longer covered by the plan on the date that the request is made.

(5) Nothing in this section shall prevent the carrier from conducting an audit of the request for reimbursement of unpaid co-payment, co-insurance, and/or deductible amounts to verify that the insured was eligible for coverage at the time of service, that the service was a covered health benefit under the applicable health benefit plan, and to verify from the provider's internal log that reasonable efforts were made to contact the insured following the criteria outlined in this section. The carrier must complete any such audit of the submitted report from the health care provider and notify the health care provider of any disputes as to the request for reimbursement within one hundred and twenty (120) days of receipt of the request for

reimbursement from the health care provider. The carrier shall pay the health care provider sixty-five percent (65%) of the undisputed amounts as submitted by the health care provider in the request for reimbursement in accordance with this section within 120 days of receipt of such requests from the health care provider. Any dispute regarding contested claims shall be subject to a dispute resolution process applicable to the arrangement between the carrier and the health care provider; and

(6)Any amounts attributable to co-payment, co-insurance, or deductible amount collected by a health care provider after reimbursement has been made by the carrier pursuant to this section shall be recorded by the health care provider and reported as an offset to future submissions to such carrier.

(d)No carrier shall prohibit a health care provider from collecting the amount of the insured's co-payment, co-insurance, and/or deductible, if any, at the time of service.

SECTION 2. The division shall promulgate regulations within ninety (90) days of the effective date of this act that are consistent with the rules developed by the Centers for Medicare & Medicaid Services for reasonable collection efforts required by a health care provider prior to submission of a request of reimbursement to a carrier. Notwithstanding the foregoing, in the event that the division fails to promulgate such regulations, the provisions of section 1 shall be self-implementing, and carriers shall make applicable payments to health care providers in accordance with the provisions of section 1 utilizing the same process adopted by the Centers for Medicare & Medicaid Services' reasonable collection efforts for bad debt, as documented in the most recent Medicare Provider Reimbursement Manual, CMS Pub. 15-1 and 15-2 (HIM-15) in effect within 90 days of the effective date of this Act. The division shall further require each

carrier to provide the division an annual report showing the total number and amount of uncollected co-payments, co-insurances, and deductibles that are reimbursed as well as those that are denied. The report shall be made publicly available on the division's website.