

CHAPTER 141 OF THE ACTS OF 2000

AN ACT RELATIVE TO MANAGED CARE PRACTICES IN THE INSURANCE INDUSTRY

ANALYSIS OF THE COMPLIANCE WITH THE REGULATIONS

2ND REPORT



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

September 2006

I. BACKGROUND

On July 21, 2000, former Governor Paul Cellucci signed Chapter 141 of the Acts of 2000, an Act Relative to Managed Care Practices in the Insurance Industry into law in the Commonwealth of Massachusetts. The law and accompanying regulations¹ became effective on January 1, 2001. This new, comprehensive law incorporated many aspects of legislation (such as, Patient Bill of Rights) that had been debated and defeated in previous years and expanded the rights and protections afforded to health care consumers, providers and the Commonwealth. Specifically, Chapter 141 included provisions addressing the following:

- Prompt Pay – requires that provider claims are acted upon (either paid, denied with a written reason for denial, or deemed incomplete with a written request for more information) within 45-days of receipt. Claims that have not been acted upon within the 45-days are subject to a 1.5 percent per month interest charge, up to a maximum of 18 percent per year, payable to the provider.
- Establishment of two new agencies, the Office of Patient Protection (within the Department of Public Health), and the Bureau of Managed Care (within the Division of Insurance). Each of these new agencies has authority over specific areas of oversight of health plan operations.
- Creation of the Managed Care Oversight Board to oversee issues involving health care cost, quality and access, and the coordination of activities between the Office of Patient Protection and the Bureau of Managed Care.
- Codification of the “*prudent layperson*” standard for coverage of emergency services provided for emergency medical conditions. The law also eliminated any plan requirements of notification prior to contacting pre-hospital emergency medical service system (i.e., 911).
- Providing special authority to the Commonwealth’s Attorney General to review the sale of a non-profit health maintenance organization or acute care hospital to an entity other than a public charity. Additionally, the Attorney General was granted the authority to monitor the charitable actions of any charitable fund created as a result of the sale if the non-profit entity does not continue to operate its hospital or health maintenance organization.

II. AGENCY ESTABLISHMENT

As referenced above, Chapter 141 established two agencies, the Office of Patient Protection and the Bureau of Managed Care, with authority to enforce and monitor compliance with the new chapter 176O, Health Insurance Consumer Protections, of the Massachusetts General Laws. Each agency is guided by a comprehensive set of regulations that addresses certain operational requirements of the plans.

A brief outline of the role of each agency and the key points of the regulations they enforce follows:

- **Office of Patient Protection (OPP):** The OPP enforces 105 CMR 128.000: health insurance consumer protection regulations. Key points of the regulations include:
 - *Clinical Decisions* – requires that all clinical decisions are made by the treating physician, are made in accordance with generally accepted principles of professional medical practice, and in consultation with the insured.
 - *Carrier’s Medical Necessity Guidelines* – if a plan develops clinical guidelines to be used in determining if services are medically necessary, the guidelines must be developed with input from practicing physicians from within the service area, developed in accordance with standards adopted by national accreditation

organizations, evidence based (if practicable), updated at least every two years, and applied in a manner that considers the individual health care needs of the insured.

- *Internal Inquiry Process* – permits plans to establish a process to be used by consumers prior to the external grievance process when they have a question or concern with their plan. Under the internal inquiry process, the plan would attempt to answer questions and/or resolve concerns to the insured's satisfaction within three business days.
- *External Review Process* -- subject to certain limitations; plan denials of coverage may be reviewed by external review agencies to determine if the coverage denial was appropriate given the individual's insurance contract, medical condition, and the service requested.
- *Disenrollment Of Primary Care Providers* – where a carrier allows or requires the designation of a primary care physician, and the disenrollment of the primary care physician is for a reason other than quality or fraud, the carrier must notify patients at least 30-days in advance that their primary care physician is being terminated from their plan provider network. Additionally, it requires the plan to continue covering the care provided to the patient for at least 30-days following the date of termination of the physician (if disenrollment is for reasons other than quality or fraud), consistent with the terms of the carrier's evidence of coverage.
- *Coverage of Pediatric Specialty Care* -- requires plan coverage for pediatric specialty care, including mental health care, by persons with recognized expertise in providing pediatric specialty care.
- *Disenrollment Of Providers Of Care To Pregnant Women* – for any female insured who is in her second or third trimester whose provider is involuntarily terminated (for reasons other than fraud or quality) the plan is required to continue providing coverage for treatment, consistent with the evidence of coverage, for the insured through the first postpartum visit.
- *Disenrollment Of Providers Of Care To The Terminally Ill* -- for terminally ill patients whose provider is involuntarily terminated (for reasons other than fraud or quality) the plan is required to continue providing coverage for treatment by the provider, consistent with the evidence of coverage, until the patient's death.
- *Coverage For The Newly Insured* -- for individuals who are newly enrolled in a plan and: (i) their previous provider is not a participating provider in any of the plans offered by the individual's employer, and (ii) the previous provider is providing an ongoing course of treatment or is the individual's primary care physician, the plan is required to provide continued coverage for the services provided by the previous provider (if the provider agrees to certain conditions) according to the following schedule:
 - any newly enrolled patient – coverage for the first 30 days of plan membership;
 - if pregnant and in the second or third trimester – coverage through the first postpartum visit; and
 - if terminally ill – coverage with the provider until the insured's death.
- *Standing Referrals* – when a carrier requires an insured to designate a primary care physician, the primary care physician is permitted to approve standing referrals for specialty health care, including mental health, provided by a health care provider participating in the carrier's network when a) the primary care physician determines that the referrals are appropriate; b) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis; and c) the health care services to be provided are consistent with the terms of the carrier's evidence of coverage.
- *Specialty Care Not Requiring Prior Authorization* – carriers that require an insured to obtain referrals or prior authorizations from a primary care physician for specialty care cannot require patients to obtain a referral or prior authorization from a primary care physician for the following types of specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner participating in the carrier's network: a) annual preventive gynecological health examinations (including follow-up care determined to be medically necessary as a result of the examination); b) maternity care; and c) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. Additionally, plans cannot impose higher co-payments, coinsurance, deductibles or additional cost sharing requirements for such services provided to the insured in the absence of a referral from a primary care physician.

- *Denial Of Provider Applications* – requires that plans provide a written explanation of why providers have been denied participation in the plan.
 - *Provider Termination Without Cause* – contracts between plans and providers must state that neither the provider nor the plan may terminate the contract without cause. Additionally, plans must provide a written explanation to a provider as to why the provider is involuntarily disenrolled.
 - *Interpreter Services* – a requirement that plans provide interpreter and translation services to their members, upon request, to explain plan administrative procedures.
 - *Annual Reporting Requirements* -- On an annual basis, no later than May 15th of each year, all plans are required to disclose information to the OPP concerning: 1) percent of premium spent on administrative versus health care services, 2) the three most common reasons for voluntary and involuntary provider disenrollment, 3) list of independent sources assessing insureds' satisfaction and evaluating the quality of health care services offered, 4) percentage of physicians who voluntarily and involuntarily disenrolled, and 5) a report detailing certain information about internal grievances. Plans are also required to submit copies of certain materials, including, but not limited to, evidence of coverage, list of providers, and a statement about the availability of physician profiling information. All of the above information is published on the OPP website.
- **Bureau of Managed Care (BMC):** The BMC enforces 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers. Key points of the regulations include:
 - *Accreditation Of Health Plans* – On an annual basis all plans within Massachusetts are required to meet nationally accepted standards concerning operational aspects, such as utilization review, quality management and improvement, and provider credentialing.
 - *Standards For Utilization Review* – a requirement that plans meet the nationally accepted standards for utilization review established by the National Commission for Quality Assurance (NCQA).
 - *Standards For Quality Management And Improvement* - a requirement that plans meet the nationally accepted standards for quality management and improvement established by the NCQA.
 - *Standards For Credentialing* - a requirement that plans meet the nationally accepted standards for credentialing established by the NCQA.
 - *Standards For Preventive Health Services* – a requirement that plans provide coverage for preventive services mandated by applicable law and meet the nationally accepted standards established by the NCQA.
 - *Provider Contracts* – requires that contracts between plans and health care providers state, among other things, that a plan cannot refuse to contract with a provider or refuse to compensate a provider for covered services solely because the provider has in good faith communicated with, or advocated for , a prospective, current or former patient regarding the health benefits plan as it relates to the needs of the patient, or because the provider has in good faith communicated with a prospective, current or former patient about the method used by the plan to compensate the provider for services provided to the patient.
 - *Evidence Of Coverage* – a requirement that carriers provide an evidence of coverage to an insured that includes a broad range of topics, such as the coverage of health care services provided through their contract, the administrative processes of the plan, and information about resources (such as, OPP) provided by the Commonwealth.
 - *Required Disclosures* – a requirement that plans provide information regarding various plan characteristics (for example, voluntary and involuntary disenrollment rate of members, a statement concerning access to emergency care services, a description of the process used to develop clinical guidelines) to at least one adult insured in each household upon enrollment and to prospective members upon request. Material changes to these disclosures must be given to existing members at least once every two years.
 - *Provider Directories* – a requirement that plans provide a directory of health care providers to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request,

and annually thereafter to at least one adult insured in each household (or to a group representative in the case of a group policy). The directory must contain, among other things, a list of health care providers that participate in the plan, organized by specialty and location, and the type of payment arrangements (for example, fee-for-service, capitation) between the plan and the provider.

- *Material To Be Provided To The Office Of Patient Protection (Annual Disclosure)* - a requirement that all plans submit certain information to the OPP, including, but not limited to: 1) a copy of every evidence of coverage and any amendments, 2) a copy of the provider directory, 3) top three reasons for voluntary and involuntary provider disenrollment, 3) list of independent sources assessing insureds' satisfaction and evaluating the quality of health care services offered, 4) percentage of voluntary and involuntary member disenrollment, and 5) a report detailing certain information about internal grievances.

Chapter 141 also required the creation of a Managed Care Oversight Board to have limited oversight authority over the OPP and the BMC to coordinate functions and review and comment upon regulations promulgated by each entity. In addition, the law created an advisory committee to advise the board on issue relating to managed care practices. The Massachusetts Medical Society (the MMS), along with 13 other persons, is appointed to the advisory committee to review and comment upon all rules, regulations and guidelines.

III. ANALYSIS OF COMPLIANCE

For the purposes of this paper, we have focused our analysis on five areas of publicly reported information: Timely Payment Provision, External Reviews, Accreditation of Plans, Annual Disclosure of Materials, and the Prudent Layperson Definition of Emergency Medical Condition. Analysis of compliance with many of the above referenced provisions (for example, Standing Referrals) within the regulations requires additional discussion and sharing of information by the health plans. The MMS is continuing its involvement with the Managed Care Advisory Committee, and working with the plans to address opportunities for improvement to further the public's awareness of the protections afforded them by the regulations.

Timely Payment Provision

The Timely Payment Provision requires insurers, within 45 days of receiving completed reimbursement forms from physicians, to make payments for the services provided, notify physicians in writing of the reason for nonpayment, or notify physicians in writing of what additional information is necessary to complete the reimbursement forms. Insurers that fail to comply with these requirements will be required to pay interest to the physician.

Health Plan Reports

In addition, several of the plans are taking proactive steps to assure their compliance with the regulations. For instance the MMS has contacted each of the plans below, who have *self-reported* their total claim payment timeliness as follows:

- *Blue Cross and Blue Shield of Massachusetts* (BCBSMA) tracks the status of claims in the aggregate to measure their rate of compliance. Currently, BCBSMA processes 99.7% of claims within 30-days. BCBSMA has programmed its interest processing to automatically calculate and process interest with the claim.
- *Fallon Community Health Plan* (FCHP) automatically tracks the status of claims and issues payment for any interest owed at the time of payment on the claim. FCHP reports that 99.73% of claims are paid within the 30-days (statistic for claims processing from January to June 2006).
- *Harvard Pilgrim Health Care* (HPHC) self-monitors on an individual claim level, and will issue an interest payment check automatically to the physician or other health care provider if action has not been taken within the allowable time frame. Additionally, HPHC reports that:

- Their inventory levels have been consistently less than three days on hand,
- Almost 97 percent of all claims are processed within 30 days of receipt, and
- Claim processing and payment accuracy rates are well within industry benchmark ranges.
- *Health New England* (HNE) has worked the prompt payment provision into their claims processing routines. According to HNE, the provision has not had a major impact in terms of volume and dollars, since on average, over 90% of in-plan claims are paid within 30 days. HNE has a process for remitting interest checks on a quarterly basis.
- *Tufts Health Plan* (Tufts HP) monitors their compliance on an individual claim level and will automatically send a check to the provider if they do not meet the 45-day timeframe. Of note, Tufts HP's average turnaround time is approximately 7.5 days for HMO and PPO and 8.5 days for POS and less than 2% of claims are processed beyond 30 days. Interest checks are mailed to providers quarterly. For Q1 and Q2 2006, 245 payees were paid approximately \$14,000 in interest payments.

Over the last four years, the plans have maintained or improved their claims processing times as illustrated in Chart 1 below.

Chart 1. Percent of Claims Processed within 30 Days, as reported by health plans

Health Plan	2003	2004	2006
BCBSMA	99.6%	99.7%	99.7%
Fallon	99%	99.51%	99.73%
HPHC	97%	97%	97%
HNE	90%	>90%	>90%
Tufts	average turnaround time is 9 days across all products	average turnaround time is 9 days across all products	98%

Physician Report

During the first quarter of 2002, the MMS conducted a survey of approximately two thousand physicians to determine the status of outstanding claims by payer. The following result, based on 2001 data, reflect responses from 1,930 physicians representing over 30,000 claims².

At 45 days, the dominant Massachusetts private payers paid claims in full on average approximately 88% of the time. National payers were reported to pay claims in full 74% of the time.

Athenahealth, Inc., a Watertown, MA provider of web-based software, knowledge, and services for medical practices, also monitors health plan compliance with the prompt payment provision for their Massachusetts customers. For Q3 2005-Q2 2006 athenahealth reports that the dominant Massachusetts private payers paid claims within 45-days 98% percent of the time. National payers were reported to pay claims within 45-days 96% of the time³.

Prompt Payment Complaints

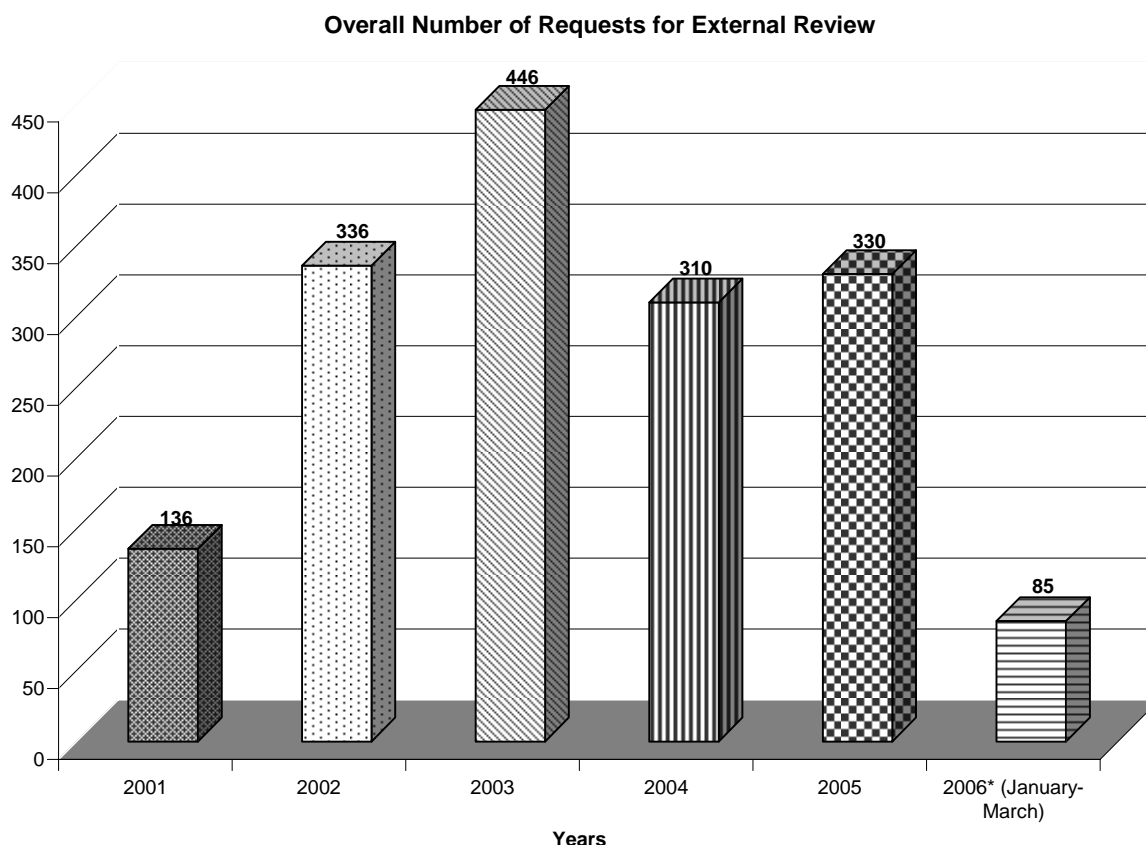
Currently, there is no formal prospective monitoring mechanism to ensure timely payment. Physicians are asked to submit complaints about delays in payment directly to the Bureau of Managed Care, who investigates

the health plans retrospectively to determine if they are complying with the law. In order to track payment issues the BMC requests that complaints from individual physicians be submitted to their office in writing. These are tracked for appropriate action. The MMS Department of Health Policy/Health Systems has experienced a decline in complaints regarding timely payment. Physicians who are experiencing slow turnaround time for payment or acknowledgment of claims should contact the MMS Physician Practice Resource Center and the Division of Insurance- Bureau of Managed Care. (See the Resource page for contact information.)

External Review Requests

In 2001, during the first year of operation for the OPP, there were only a limited number of requests for external review. This may have been due to the fact that providers and patients may not have been aware of the resources available to them and did not take advantage of the opportunity for external review. The OPP had received one hundred thirty six (136) requests for review during that year⁴. In 2002, total requests for external review had risen to 336 requests. In 2003 the number of external review requests spiked to an all-time high of 446 requests, representing a 20% increase from the previous year. In 2004 and 2005 external review requests were reduced to 310 and 330, respectively. For 2006, the amounts of requests seem to follow a similar trend. (Refer to Chart 2 below.)

Chart 2: Number of External Review Requests 2001-2006 (January-March 2006)



- As illustrated in Chart 3 and 3a, behavioral health services continue to be the area of care with the highest percentage of requests for external review since the implementation of the law. Additionally, there has been a ten percent (10%) increase in the percent of external review requests for outpatient services from 2003 to 2005. According to the OPP, part of this rise could be attributed to the 2003 FDA approval of growth hormone for idiopathic short stature which increased these types of requests.
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Chart 3: Requests for External Review/Categories, 2001 – 2006(January - March)

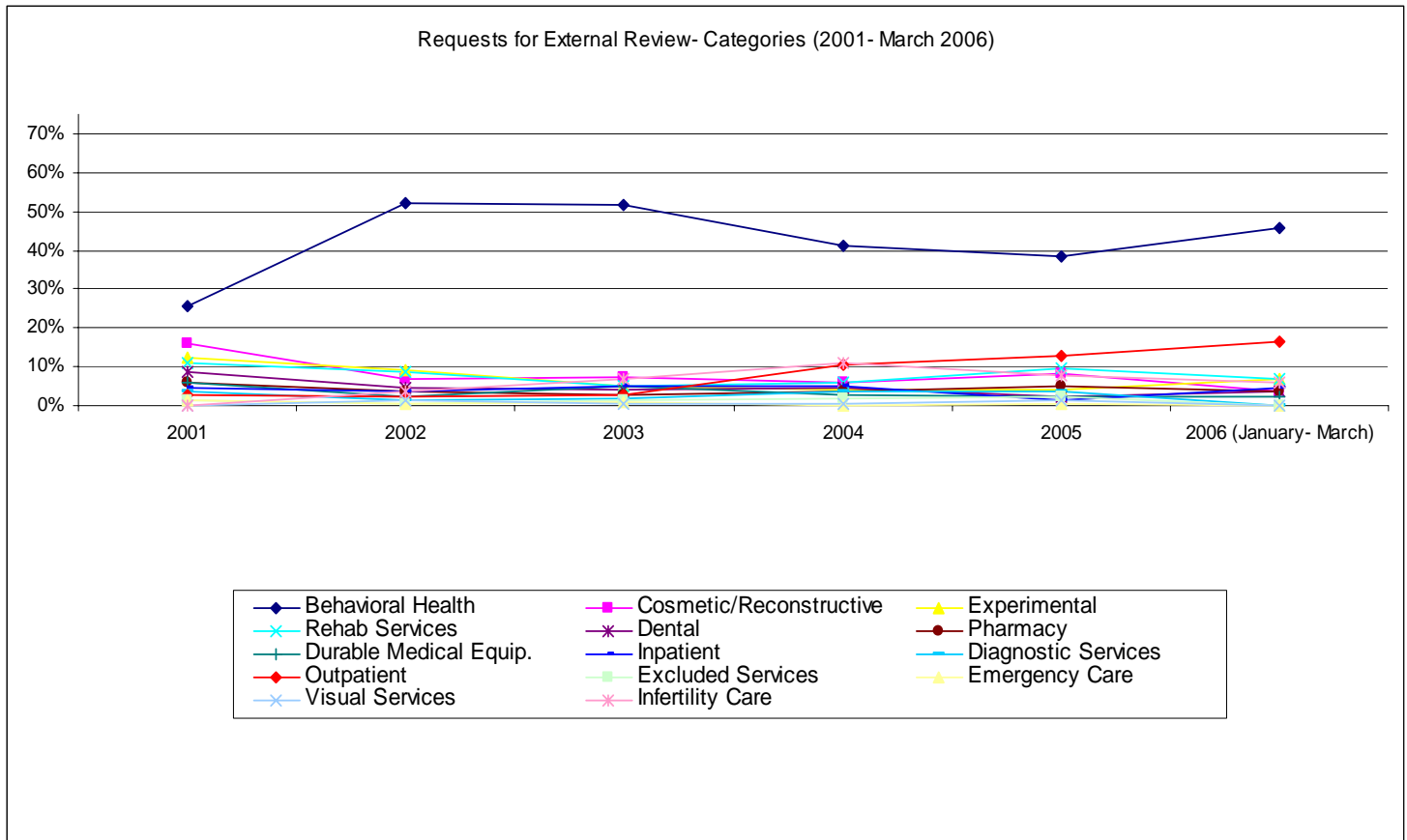


Chart 3a: Requests for External Review- Categories (2001-March 2006)

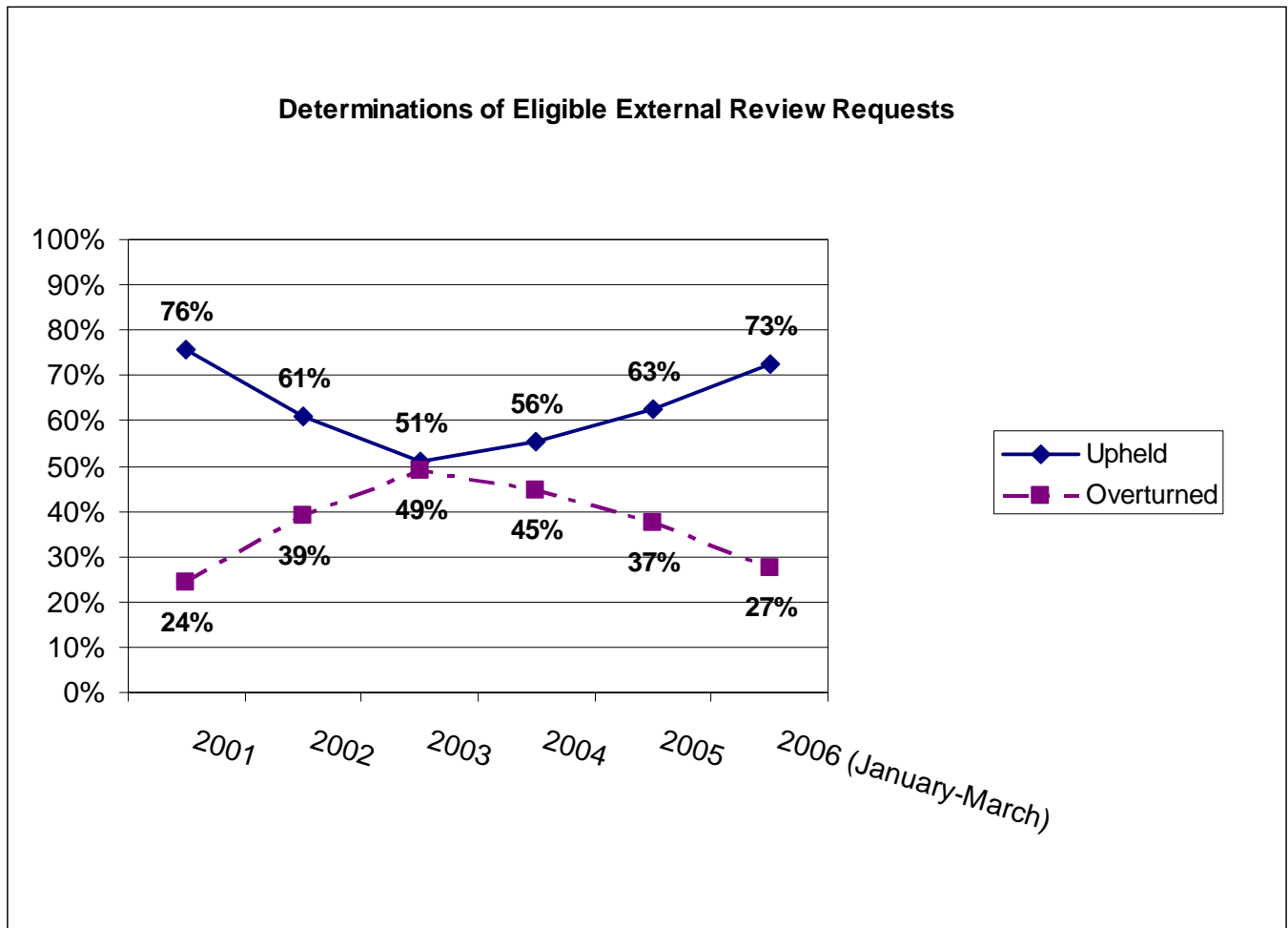
	2001	2002	2003	2004	2005	2006 (January- March)
Behavioral Health	25.7%	52.1%	51.6%	41.0%	38.5%	45.9%
Cosmetic/Reconstructive	16.2%	6.8%	7.2%	6.1%	8.2%	3.5%
Experimental	12.5%	8.9%	4.9%	4.2%	3.9%	7.1%
Rehab Services	11.0%	8.6%	4.9%	5.8%	9.7%	7.1%
Dental	8.8%	4.5%	4.0%	4.5%	2.1%	3.5%
Pharmacy	5.9%	3.6%	2.9%	3.9%	5.2%	3.5%
Durable Medical Equip.	5.9%	2.1%	4.9%	2.9%	2.4%	2.4%
Inpatient	4.4%	3.9%	4.9%	4.8%	1.5%	4.7%
Diagnostic Services	3.7%	1.2%	1.8%	3.5%	3.6%	0.0%
Outpatient	2.9%	2.1%	2.9%	10.3%	12.7%	16.5%
Excluded Services	1.5%	0.6%	1.6%	1.6%	2.1%	0.0%
Emergency Care	1.5%	0.6%	0.9%	0.0%	0.6%	0.0%
Visual Services	0.0%	1.5%	0.7%	0.3%	1.5%	0.0%
Infertility Care	0.0%	3.6%	6.7%	11.0%	7.9%	5.9%

External Review Results

An “overturn” is when the plan made a decision that the external review agency determined was incorrect based upon the individual’s medical condition, the physician’s request, standards of care and the coverage provided by the plan. An “upheld” decision would occur when the external review agency agrees with the decision of the plan based upon the individual’s medical condition, the physician’s request, standards of care and the coverage provided by the plan. “Ineligible” determinations are when the OPP determines that an external review is not appropriate, based upon a variety of factors such as time limitations for submission for review, defined coverage parameters of the plans, or if the individual has not exhausted all the plan’s internal appeal processes.

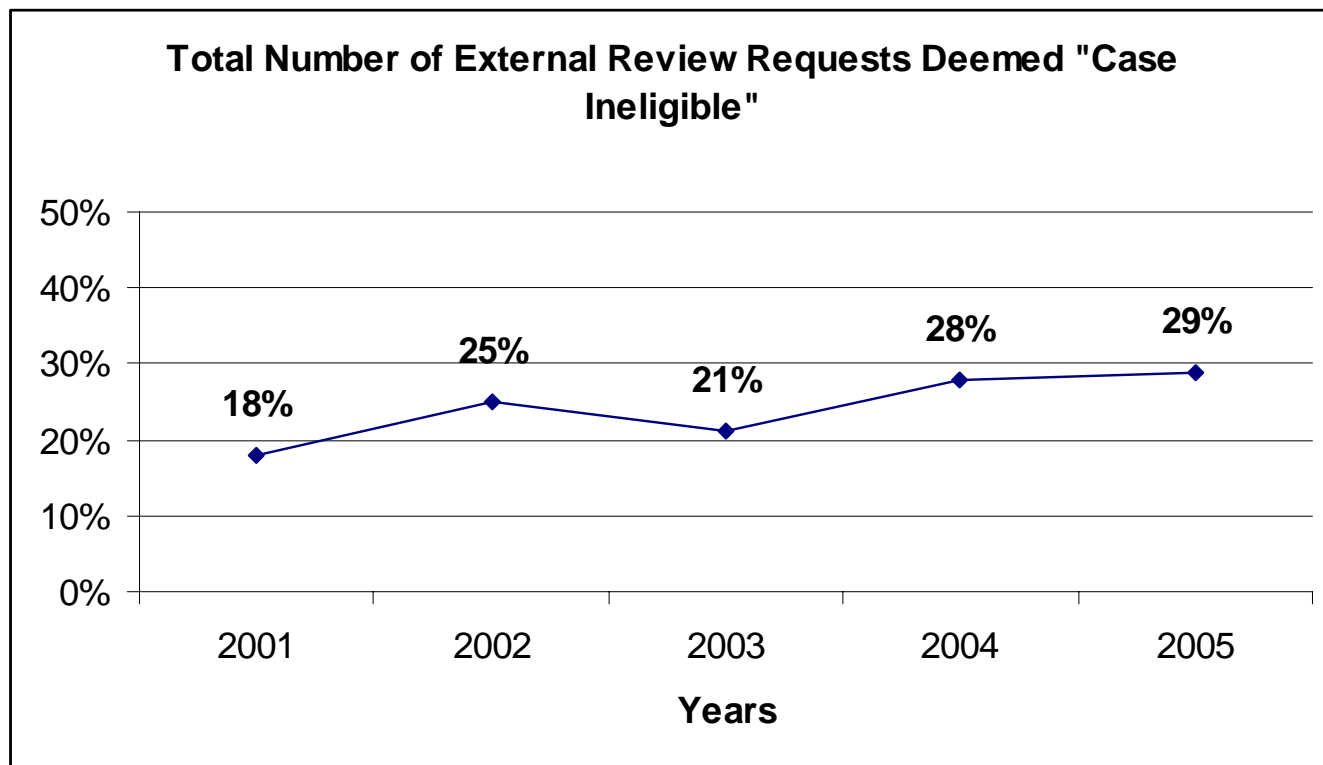
Between 2001 and 2003, there was a 25% increase in the overturn rate (plan decision was reversed), and a 25% decrease in the upheld rate (plan decision remains). Since 2003, there has been a decrease of 22% in the overturn rate, with a 22% increase in the number of cases upheld. In addition, the number of cases deemed ineligible has continued to rise since 2003 (Refer to Chart 4 and 5 below.)

Chart 4: Determinations of Eligible External Review Requests



Note: Data in Chart 4 does not include external review requests that have been resolved prior to review, cases in which the filing time-limit expired, cases deemed to be ineligible prior to review, nor open cases.

Chart 5: Total Number of External Review Requests Deemed “Case Ineligible”



Analysis

Despite the dramatic increase in the number of requests for external review in 2003, it appears that the number of external requests is evening off to an average of 325 requests per year. The OPP found that on average over the last five years, one-quarter of the cases submitted by enrollees are ineligible for review due to a variety of reasons (for example, defined within the evidence of coverage as “not covered” or “excluded”, time-limit expiration). Additionally, while there had been a three year trend of the plan decisions being overturned more frequently, the initial health plan decisions are now more frequently upheld.

The increase of overall requests could be attributed to the Department Of Insurance (DOI) requirement that plans provide adequate notice to their enrollees of their external review rights, or the general increased public awareness of insureds’ rights to have their denials of coverage reviewed by the OPP. Additionally, the changes in the rates of overturns, upholds and ineligible may be related to improved operations (such as, internal review processes) of the insurers and the OPP.

Accreditation of Health Plans

In the first year following implementation of Chapter 141 regulations, 100% (n=49) of the managed care plans received a one-year accreditation.⁵ Likewise during 2002 the DOI conducted their second annual review of plans for accreditation and reported that again 100% (n=49) of the managed care plans in Massachusetts received accreditation effective August 1, 2002.⁶ For 2003, the DOI successfully aligned the plan licensing and the accreditation timeframes to occur simultaneously. The 2003 annual report of the DOI reports that the Bureau of Managed Care completed annual accreditation of 39 managed care plans and licensure of 12 health maintenance organizations⁷. Since 2003, two health plans have notified the DOI that they were not renewing business in MA. Currently nine of the ten health maintenance organizations in Massachusetts are fully accredited by the National Committee for Quality Assurance (NCQA). Note that 100% have achieved a rating of “Excellent”.⁸

The DOI will use data from NCQA between April-August of this year for their accreditation review. Although initial accreditation is ongoing, there are currently no new entrants to the insurance market in Massachusetts. However, there are four (4) Qualified Student Healthcare Programs that are “splinter” plans. Coordinated Health Partners, Inc. has withdrawn from the Massachusetts market, but may still see patients through its Rhode Island provider networks. Coordinated Health Partners has agreed to continue honoring the Massachusetts mandates for the individuals. Additionally, One Health Plan of Massachusetts, Inc. changed its name to Great-West Healthcare of Massachusetts, Inc., effective July 21, 2003. The carrier notified the Division on September 6, 2002 that it would discontinue marketing all group business on October 7, 2002 and begin non-renewing business as of May 1, 2003⁹.

Analysis

This section of the regulations simply codifies what is, and had been, the market driven industry standard for accreditation of quality. Since implementation of this law, 100% of the managed care plans in Massachusetts received accreditation by the DOI. Additionally, the nine plans that have NCQA accreditation represent 93% of the managed care enrollment, or 1,791,768 people within Massachusetts¹⁰. The remaining plans may have chosen not to undergo NCQA review due to their limited enrollment, or may be accredited by other organizations.

Annual Reporting Requirements – Public Disclosure and Availability

On an annual basis (no later than May 15th of each year) managed care plans are required to submit reports to both the DOI and the OPP regarding issues such as percent of premium used for health care services, the number of internal grievances, and the top three reasons for provider contract termination. The information is released publicly through the OPP’s web site (<http://www.state.ma.us/dph/opp/index.htm>). As referenced above some of the useful information that health care consumers could use in choosing their plan includes:

- *Number of Internal Grievances*¹¹ – In 2006, the dominant plans report numbers of internal grievances as follows:

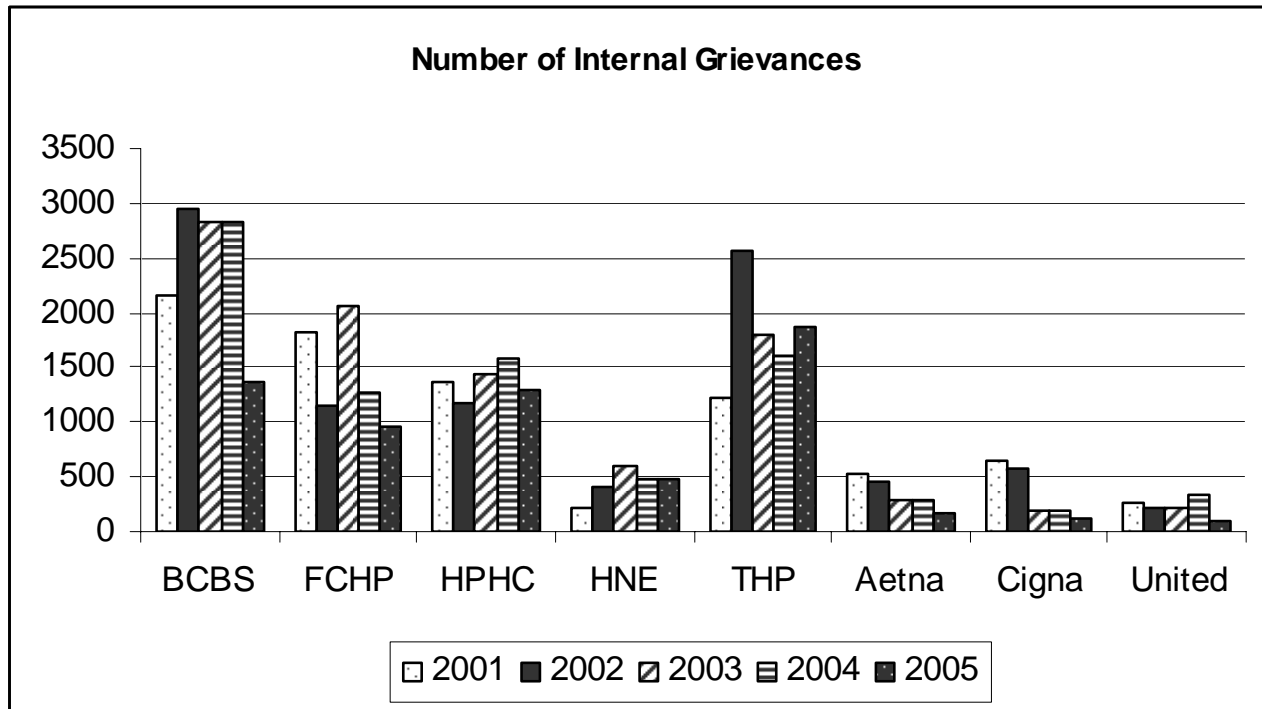
Plan Name	# of Internal Grievances	# of Grievances Approved	# of Grievances Denied	# of Members ¹²
Non-Profit Plans				
Blue Cross Blue Shield of Massachusetts (HMO Blue)	1364	800	332	852,900
Fallon Community Health Plan	966	472	414	156,758
Harvard Pilgrim Health Care	1300	583	655	407,638
Tufts Health Plan	1871	380	1449	293,824
For-Profit Plans				
Aetna/US Healthcare	169	60	82	5567
CIGNA HealthCare of Massachusetts, Inc.	122	57	63	6657
Health New England	478	218	253	62,559
United Healthcare of New England	97	54	41	1034

Note: The total number of internal grievances approved and denied may not equal the total number of grievances at the plan due to appeals that were withdrawn before resolution.

Health care consumers may find this information useful in determining the frequency of problems or complaints that the plan members have with the plan(s). Additionally, significant changes in the overall number of grievances that are filed should not be taken as an indicator of new problems with the plan(s), but rather may be attributable to increased member education on their ability to file a grievance. Note: when comparing the number of complaints among plans, the size of the plan membership should be considered. In addition, the percent of

internal grievances that are subsequently approved should be considered by consumers and physicians in an effort to determine if the initial denials are appropriate.

Chart 6: Number of Internal Grievances, by Plan (2001 - 2005)

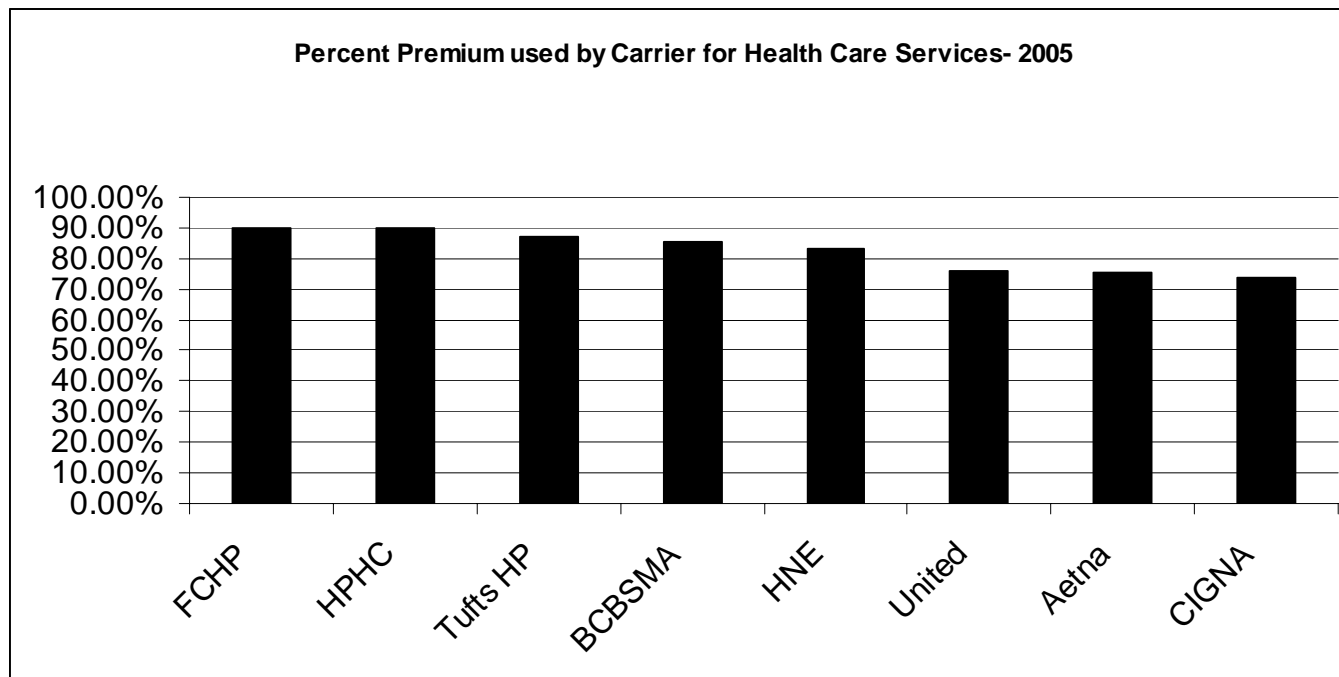


- *Percent Of Premium Revenue Used By Carrier For Health Care Services*⁴³ - In 2005, the dominant non-profit plans report the percentage of premium used for health care services as follows:
 - 85.70% - Blue Cross Blue Shield of Massachusetts;
 - 90.20% - Fallon Community Health Plan;
 - 89.75% - Harvard Pilgrim Health Care;
 - 83.45% - Health New England; and
 - 87% - Tufts Health Plan.

Overall the for-profit plans report similar percentages as follows:

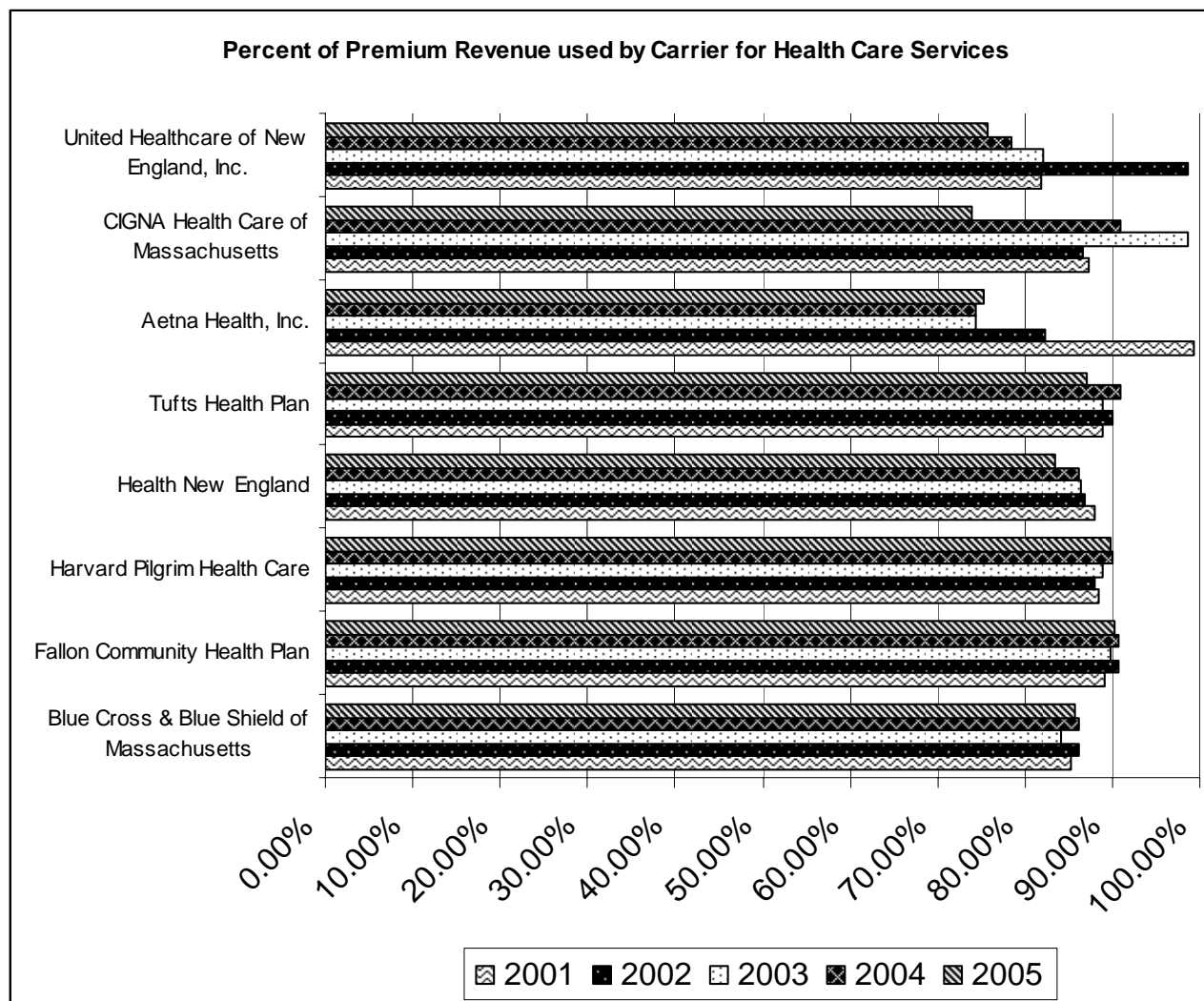
- 75.20% – Aetna Health;
- 74% – Cigna; and
- 75.70% - United Healthcare

Chart 7- Percent Premium used by Carrier for Health Care Services- 2005



This information can be useful to help determine which plan provides the best value for the premium (in terms of dollars spent on health care services versus administrative services). Additional information concerning the compensation levels of senior management positions at the plans may be obtained by contacting the Commonwealth's Office of the Attorney General (<http://www.ago.state.ma.us>). As demonstrated in Chart 8 below, health care consumers can evaluate the plans based upon the percent of premium used for health care expenses versus administrative expenses.

Chart 8 – Percent of Premium Revenue used by Carrier for Health Care Services



- *Top Three Reasons for Provider Contract Termination* - Various reasons for provider contract termination are reported by the plans. The most common are relocation, retirement, and non-compliance with recredentialing process.¹⁴

Additionally, OPP produces case summaries of all the external reviews conducted during the reported year with the outcomes and rationale for the determination, which are also available on its web site.

Another source of information accessible by the public is the Guide to Managed Care in Massachusetts (available at http://www.mass.gov/Eeohhs2/docs/dhcfp/pubs/mgd_care_guide.pdf), which provides consumers with an overview of the types of plans available, factors to consider when selecting a plan, a profile of the HMOs, listing of accredited plans, member satisfaction ratings, summary information about each of the plan's performance related to certain quality measures, and general information regarding how to handle complaints with the plans.

Analysis

All of the information that is required to be reported by the managed care plans is updated and available on the OPP website (<http://www.mass.gov/dph/opp/data.htm#annual>). Although the information is relevant and

useful to healthcare industry professionals and researchers, more public education would be useful to make sure that health care consumers are able to understand how the information could help guide their choice to enroll in one plan over another. Additionally, further public information regarding the definition of what health plans include in their reports as “health care services” should be provided.

Prudent Layperson Definition of “Emergency Medical Condition”

Included within Chapter 141 of the Acts of 2000 is the prudent layperson definition of emergency medical condition. The definition reads as follows:

“Emergency medical condition’, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).”

Before the enactment of Chapter 141, many plans required their insured members to contact plan administrative offices to receive approval prior to seeking emergency medical care services. Physicians and patients had viewed this requirement as an unnecessary step for sick or injured individuals seeking necessary care.

Analysis

The definition of “emergency medical condition” helps to eliminate any requirements that plans imposed on insureds to contact their plan to receive approval (or be redirected to other types of care) prior to receiving emergency medical care. Both insured individuals and emergency care physicians/hospitals have benefited from the “prudent layperson” definition. Insured individuals can immediately seek and receive emergency medical care without being concerned about receiving approval from their plan, and providers are assured payment for services they have provided in accordance with the evidence of coverage.

IV. CONCLUSIONS

As intended, Chapter 141 of the Acts of 2000 has provided the legal and regulatory structure to improve access to care by the health care consumers in the Commonwealth of Massachusetts.

The regulations require managed care plans to pay for health care services if they are a covered benefit under the plan and are medically necessary. In situations where health plans have denied coverage, patients have an opportunity to have their case reviewed by an external review organization on an objective basis. Additionally, the regulations support some degree of continuity of care between established patients and physicians when patients select a new managed care plan.

The prompt payment provision of the law has been successful in establishing parameters that all of the plans must adhere to regarding the timeliness of adjudication, either as payment, denial of payment with a clear written explanation as to the reason(s), or temporary nonpayment with a written request for additional information. Prior to this provision of the law, physicians and other providers had little to no recourse with the plans with respect to outstanding claims. Based on the self-reported data, it appears that the health plans are adhering to the provision to pay interest on claims that were not responded to within the forty-five day period; however, this data is not regulated or audited by any government or third-party organization.

To meet the true intent of the law and accompanying regulations, public education should continue so that health care consumers understand how to best interpret and use the information that is annually reported by the managed care plans. Additionally, amendments to the regulations are necessary to require that all of the miscellaneous provisions discussed above are provided to newly insured individuals upon enrollment. Such amendments would provide the healthcare consumer with a more gentle transition from their previous physician to a new physician, or alternatively continue care with their existing physician until the conclusion of their medical condition.

Additionally, the scope of Chapter 141 and related sections should be expanded to include all health plans in Massachusetts, with the exception of Medicare. Currently the law only applies to health plans in Massachusetts that are not federally funded or self-insured. Therefore, individuals covered by MassHealth, Medicare, Medicare Advantage Plans, or a self-funded group are not covered by these health care consumer protections, and these insurers do not have to adhere to the regulations. MMS has submitted legislation to expand on this successful process and the protections afforded to health care consumers under Chapter 141 to individuals enrolled in the MassHealth program.

Based on the success of Chapter 141 as it relates to regulations for prompt payment, it may be appropriate to lessen the 45-day prompt payment provision to 30-days. Many states around the country are operating with 30-day prompt payment laws. It may also be valuable to pursue a requirement for final payment within 45 days of submitting a completed claim.

In addition, the MMS and other health care organizations may consider working with the health plans as well as introducing additional legislation related to further transparency of health care coding rules and payment policies as well as a detailed breakdown of the services included in the term “health care services” to further balance the environment for patients and physicians.

RESOURCES

Bureau of Managed Care, Division of Insurance

(617) 521-7372

http://www.mass.gov/doi/Managed_Care/managed_care_home.html

Commonwealth's Office of the Attorney General

(888) 830-6277

<http://www.ag.state.ma.us>

Division of Health Care Finance and Policy

617-988-3100

<http://www.mass.gov/dchfp>

Massachusetts Office of the Managed Care Ombudsman

(800) 436-7757

MMS Physician Practice Resource Center

(781) 434-7222

pprc@massmed.org

<http://www.massmed.org/pprc>

Office of Patient Protection, Department of Public Health

(800) 436-7757

<http://www.mass.gov/dph/opp>

Chapter 141 The Acts of 2000

<http://www.mass.gov/legis/laws/seslaw00/sl000141.htm>

Health Plans

Aetna Health Inc.

(800) 624-0756

www.aetna.com

BCBSMA

(800) 316-BLUE (2583)

www.bcbsma.com

CIGNA Healthcare of Massachusetts, Inc.

(800) 88CIGNA (882-4462)

www.cigna.com

Fallon Community Health Plan

(866) ASK-FCHP (866-275-3247)

www.fchp.org

Harvard Pilgrim Healthcare, Inc.

(800) 708-4414

www.harvardpilgrim.org

Health New England

(800)842-4464

www.hnc.com

Tufts Health Plan

(888) 884-2404

www.tuftshealthplan.com

UnitedHealthcare of New England, Inc.

(800) 521-2603

www.unitedhealthcare.com

¹ 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers, 105 CMR 128.00: Health Insurance Consumer Protection Regulations

² Holmes, D. Prompt Payment Survey Shows Opportunities for Improvement, Massachusetts Medical Society, Vital Signs, October 28, 2002 (<http://www.massmed.org/vitalsigns/nov02/yp1.html> - accessed June 13, 2003).

³ Athenahealth, Inc., Prompt Payment Compliance Report August 2005-July 2006- provided to MMS August 18, 2006.

⁴ Massachusetts Department of Public Health, Office of Patient Protection, External Review Requests January 2001 – December 2001 (http://www.state.ma.us/dph/opp/external_review_01.pdf – accessed May 26, 2003)

⁵ Division of Insurance, 2001 Annual Report, (http://www.state.ma.us/doi/Media/media_annual_2001_FS.html#SRB - accessed June 4, 2003)

⁶ Division of Insurance Completes Annual Managed Care Accreditation Review Focuses on Provider Networks & Mental Health Systems, Division of Insurance Press Release, July 31, 2002 (http://www.state.ma.us/doi/Media/media_press36.html – accessed June 4, 2003)

⁷ Massachusetts Division of Insurance, 2003 Annual Report, (http://www.mass.gov/doi/Media/media_annual_FS.html- accessed August 17, 2006)

⁸ National Committee for Quality Assurance, Health Plan Report Cards, (<http://hprc.ncqa.org/frameset.asp> – updated as of 6/30/2006, accessed August 14, 2006)

⁹ Division of Insurance, Quarterly Report of Membership in Health Maintenance Organizations as of March 31, 2006 (http://www.mass.gov/doi/Managed_Care/Hmo/3q03Dist_trend.pdf - accessed August 14, 2006)

¹⁰ Source of information: the combined membership enrollment as of March 31, 2006 as reported by the Division of Insurance (Quarterly Report of Membership in Health Maintenance Organizations as of March 31, 2006) and the list of NCQA accredited HMOs in Massachusetts as reported by the National Committee for Quality Assurance.

¹¹ Massachusetts Department of Public Health, Office of Patient Protection, Year 2006 Requirements for Massachusetts Health Plans, Health Plan Grievances (http://www.mass.gov/Ecohhs2/docs/dph/patient_protection/internal_grievances_06.pdf – accessed August 14, 2006)

¹² Massachusetts Division of Insurance, Quarterly Report of Membership in Health Maintenance Organizations as of March 31, 2006 (http://www.mass.gov/doi/Managed_Care/Hmo/1q06Dist_total.pdf – accessed August 14, 2006)

¹³ Massachusetts Department of Public Health, Office of Patient Protection, Years 2001-2006 Requirements for Massachusetts Health Plans, Percentage of Premium used by Carrier for Health Care Services ([http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Researcher&L2=Insurance+\(including+MassHealth\)&L3=Managed+Care+Protections+and+Grievances&L4=Annual+Reporting+Requirements+for+Massachusetts+Health+Plans&sid=Ecohhs2](http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Researcher&L2=Insurance+(including+MassHealth)&L3=Managed+Care+Protections+and+Grievances&L4=Annual+Reporting+Requirements+for+Massachusetts+Health+Plans&sid=Ecohhs2) – accessed August 14-17, 2006)

¹⁴ Massachusetts Department of Public Health, Office of Patient Protection, Year 2006 Requirements for Massachusetts Health Plans, Top Three Reasons for Contract Termination (http://www.mass.gov/Ecohhs2/docs/dph/patient_protection/voluntary_termination_06.pdf http://www.mass.gov/Ecohhs2/docs/dph/patient_protection/involuntary_termination_06.pdf- accessed August 17, 2006))