SECRETARY OF STATE
REGULATIONS DIVISION

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211 CMR 153.00: CONTINUITY OF CARE ACCESS TO COMPREHENSIVE CANCER CENTERS, PEDIATRIC HOSPITALS, AND PEDIATRIC SPECIALTY UNITS FOR SMALL GROUP HEALTH BENEFIT PLANS THAT UTILIZE LIMITED, REGIONAL OR TIERED PROVIDER NETWORKS

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153.01: Purpose, Scope and Authority

211 CMR 153.00 provides guidance and definitions for terms set forth in St. 2012, c. 61, which amends M.G.L. c. 176J. The guidance and definitions are for continuity of care access to Comprehensive Cancer Centers, Pediatric Hospitals, and Pediatric Specialty Units for Health Benefit Plans offered to Eligible Small Businesses or Eligible Individuals that utilize Limited, Regional and Tiered Provider Networks. 211 CMR 153.00 is promulgated pursuant to the Commissioner's authority under St. 2012, c. 61 and M.G.L. c. 176J, § 11A.

153.02: Definitions

As used in 211 CMR 153.00, the following words mean:

Active Course of Medical Treatment: treatment that is:

(a) delivered following an inpatient stay or outpatient procedure and designed to assure recovery/rehabilitation; or
(b) continuing care for a Serious Disease that requires periodic diagnostic studies or adjustment of medications or treatments at least every six months.

An Active Course of Medical Treatment does not include services considered preventive in nature, or services provided for the monitoring or surveillance of the patient's condition following the completion of the treatment protocol for the Serious Disease, nor does it include clinical trials, experimental treatments, off-label use for products, or products not approved by the Food and Drug Administration, except insofar as coverage is mandated as set forth in M.G.L. c. 175, § 110L, c. 176A, § 8X, c. 176B, § 4X and c. 176G, § 4P.

Adverse Determination: a determination, based upon a review of information provided, by a Carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other Health Care Services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Carrier: an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a non-profit medical service corporation organized under M.G.L. c. 176B; or a health maintenance organization organized under M.G.L. c. 176G.

Commissioner: the Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Comprehensive Cancer Center the term Comprehensive Cancer Center shall have the same meaning as that term is defined in M.G.L. c. 118G, §1, but shall be limited herein to only those entities in Massachusetts.

Commonwealth: the Commonwealth of Massachusetts.

Eligible Individual: an individual who is a resident of the Commonwealth and who is not seeking individual coverage to replace an employment-based Health Benefit Plan for which the individual or individual's dependent is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage as defined by Connector regulation 956 CMR 5.00, provided, however, that any person enrolled in an individual Health Benefit Plan before September 30, 2010 shall be considered an Eligible Individual so long as such person continues to be a resident of the Commonwealth and maintains enrollment in an individual Health Benefit Plan.

Eligible Small Business or Group: any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom worked in Massachusetts; provided, however, that the sole proprietorship, firm, corporation, partnership or association need not have been in existence during the preceding year in order to qualify as an Eligible Small Business or Group. A business shall be considered to be one eligible small business or group if:

(a) it is eligible to file a combined tax return for purpose of state taxation; or
(b) its companies are affiliated companies through the same corporate parent.

Except as otherwise specifically provided, provisions of 211 CMR 153.00 which apply to an eligible small business will continue to apply through the end of the rating period in which an eligible small business no longer meets the requirements of Eligible Small Business or Group. An eligible small business that exists within a Multiple Employer Welfare Arrangement (MEWA) shall be subject to 211 CMR 153.00.

Evidence of Coverage: any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the benefits to which the Insured is entitled.

General Provider Network: the most comprehensive provider network offered by a Carrier in its Massachusetts Service Area.

Health Benefit Plan: the term Health Benefit Plan shall have the same meaning as that term is defined in M.G.L. c. 176J, § 1.

Health Care Services: services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Insured: any policyholder, certificate holder, subscriber, member or other person on whose behalf the Carrier is obligated to pay for and/or provide Health Care Services.

Limited Provider Network: a reduced or selective Provider Network, not a Regional Provider Network, which is smaller than a Carrier's General Provider Network and from which the Carrier may choose to exclude from participation other providers who participate in the Carrier's Regional Provider Network or General Provider Network.

Pediatric Hospital: the term Pediatric Hospital shall have the same meaning as that term is defined in M.G.L. c. 118G, § 1, but shall be limited herein to only those entities in Massachusetts.

Pediatric Specialty Unit: the term Pediatric Secialty Unit shall have the same meaning as that term is defined in M.G.L. c. 118G, § 1, but shall be limited herein to only those entities in Massachusetts.

Plan Year: the twelve-month period beginning on a newly enrolled subscriber's initial effective date of coverage for health insurance coverage under a Health Benefit Plan with a Limited, Tiered, or Regional Provider Network.

Provider Network: a group of Health Care Providers contracted with a Carrier or affiliate to provide Health Care Services to Insureds covered by any or all of the Carrier's or affiliate's Health Benefit Plans, policies, contracts or other arrangements. Provider Network shall not mean those participating providers that provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B, but shall include network providers that are subject to M.G.L. c. 176I.

Regional Provider Network: a Provider Network for a defined geographic area within Massachusetts that is smaller than the Carrier's Service Area and includes only those providers that have agreed to participate in the Carrier's Health Benefit Plan in a limited geographic area within the Commonwealth. A Regional Provider Network may be a geographic subset of the Carrier's General Provider Network.

Serious Disease: a condition that is life threatening or is likely to lead to serious or permanent disability if left untreated.

Service Area: the geographical area, as approved by the Commissioner, within which the Carrier has developed a Provider Network to afford adequate access to Insureds for covered benefits.

Tiered Provider Network: a Provider Network in which a Carrier assigns providers to different benefit tiers based on the Carrier's assessment of a provider's relative cost and, where available,

quality and in which Insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a provider's assigned benefit tiers.

Undue Hardship: circumstances that:

(a) could endanger life, cause suffering or pain, or cause physical deformity or malfunction; or
(b) require the Insured to undertake a substantial change in recommended treatment for covered Health Care Services; or
(c) require the Insured to receive covered Health Care Services from multiple providers/facilities in an uncoordinated manner which will significantly worsen the Insured's Serious Disease.

153.03: Notice to Insureds in Limited, Regional and Tiered Provider Network Plans Offered to Eligible Small Businesses or Eligible Individuals

A Carrier with a Health Benefit Plan offered to Eligible Small Businesses or Eligible Individuals that utilizes a Limited, Regional or Tiered Provider Network shall issue and deliver a notice relating to access to continuity of care, separate from the evidence of coverage for said plan. The Carrier shall post said notice prominently on its website and shall issue and deliver said notice to each member household on or before June 15, 2012, and, thereafter, to all newly Insured member households prior to the effective date of coverage. Such notice shall describe:

(1) the Insured's rights to continuity of care access under 211 CMR 153.04;

(2) the process by which the Insured and the Insured's provider may pursue access to continuity of care at a Comprehensive Cancer Center, a Pediatric Hospital, or a Pediatric Specialty Unit under 211 CMR 153.04;

(3) the importance of the Insured or the Insured's provider informing the Carrier that continuity of care access is being sought prior to the Insured's receipt of any covered Health Care Services that are subject to a continuity of care access determination under 211 CMR 153.04; and

(4) the Insured's possible liability for charges if continuity of care is accessed in violation of 211 CMR 153.04.

153.04: Access to Continuity of Care

(1) For an Insured who

(a) is receiving an Active Course of Medical Treatment from a health care provider for a Serious Disease, including but not limited to cancer or cystic fibrosis, that if disrupted in the course of such medical treatment would pose an Undue Hardship to the Insured; and
(b)

(i) began this Active Course of Medical Treatment before being enrolled in a Limited, Regional or Tiered Provider Network plan where the provider is not part of the Limited, Regional or Tiered Provider Network; or

(ii) began this Active Course of Medical Treatment before being enrolled in a Tiered Provider Network plan where the provider is in the highest cost-sharing tier;

the Carrier shall provide coverage for those medically necessary and covered Health Care Services that are part of that Active Course of Medical Treatment provided by that health care provider, to the extent required by subsection (2).

(2) A Carrier to which subsection (1) applies shall provide coverage for the health care provider's covered Health Care Services for the duration of the Active Course of Medical Treatment during the Plan Year if

(a) the Insured's employer offers the Insured only a choice of Limited, Regional or Tiered Provider Network plans in which the health care provider is not part of any of the offered Limited, Regional or Tiered Provider Networks or a choice of Tiered Provider Network plans in which the health care provider is in the highest cost-sharing tier; and

(b) that health care provider is a Comprehensive Cancer Center, Pediatric Hospital or Pediatric Specialty Unit; and

(c) that health care provider is providing the Insured with an Active Course of Medical Treatment that is not available from another provider in the Provider Network of the Insured's Health Benefit Plan.

(3) For covered Health Care Services provided under this section from a provider that is not in the Provider Network of the Insured's Health Benefit Plan, patient cost-sharing shall be at the lowest cost-sharing level applicable to those covered Health Care Services in the Health Benefit Plan, and reimbursement shall be based on median in-network rates of the specific health care provider in that Carrier's private Health Benefit Plans in a manner consistent with data filed by that Carrier with the Division of Health Care Finance and Policy; provided, however, that if the specific health care provider does not participate in any other Health Benefit Plan of the Carrier, then based on negotiated rates. For covered Health Care Services provided under this section by a provider in the highest cost-sharing tier of a Tiered Provider Network plan, patient cost-sharing shall be based on the second-highest cost-sharing tier in that plan.

(4) Notwithstanding subsection (2) of 211 CMR 153.04, for an Insured who, before the effective date of 211 CMR 153.00:

(a) began an Active Course of Medical Treatment from a health care provider that is a Comprehensive Cancer Center, Pediatric Hospital or Pediatric Specialty Unit, including but not limited to, cancer or cystic fibrosis, that if disrupted in the course of medical treatment would pose an Undue Hardship to the patient; and

(b)

(i) began this Active Course of Medical Treatment before being enrolled in a Limited, Regional or Tiered Provider Network plan where the provider is not part of the Limited, Regional or Tiered Provider Network; or

(ii) began this Active Course of Medical Treatment before being enrolled in a Tiered Provider Network plan where the provider is in the highest cost-sharing tier;

the Carrier shall provide coverage for those medically necessary and covered Health Care Services that are part of that Active Course of Medical Treatment provided by that health care provider until April 30, 2013 at the patient cost-sharing levels and reimbursement rates required by subsection (3) of 211 CMR 153.04.

153.05: Denial of Access to Continuity of Care

A Carrier's determination to deny an Insured access to continuity of care under 211 CMR 153.04 is an Adverse Determination subject to the protections of 105 CMR 128.00.

153.06: Severability

If any section or portion of a section of 211 CMR 153.00, or the applicability therof to any person or circumstance is held invalid by any court competent jurisdiction, the remainder of 211 CMR 153.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.