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Bulletin 00-19

To: **Carriers Offering Health Coverage in Massachusetts**

From: **Commissioner Linda Ruthardt**

Re: **Issues Related to Chapter 141 of the Acts of 2000 Effective January 1, 2001**

Date: **December 27, 2000**

****PLEASE NOTE****

This bulletin applies to all preferred provider plans and all plans that perform any type of utilization review, including those with second opinion or other requirements.

Carriers that offer, sell, issue, deliver, make effective or renew health coverage in Massachusetts are advised to review the contents of this bulletin regarding provisions that become effective January 1, 2001.

Introduction

The purpose of this bulletin is to advise carriers regarding the implementation of Chapter 141 of the Acts of 2000 (Chapter 141). As noted in Bulletin 00-14, Chapter 141 was signed into law on July 21, 2000. Among its provisions, Chapter 141 directs changes to the delivery of managed care in Massachusetts and creates new oversight bureaus within existing state agencies. **This bulletin clarifies certain procedural requirements for carriers' compliance with the law.**

Required Disclosures

Carriers are required to develop evidences of coverage and disclosures consistent with the provisions of sections 6 and 7 of Chapter 176O. Although the Division's regulations will establish a process for the completion of these documents, the Commissioner considers the following patient protections to be of

such importance that carriers are expected to forward notice of them to all insureds[1] by no later than January 31, 2001.

- A statement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances:
  - Failure by the insured or other responsible party to make payments required under the contract;
  - Misrepresentation or fraud on the part of the insured;
  - Commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause;
  - Relocation of the insured outside the service area of the carrier; or
  - Non-renewal or cancellation of the group contract through which the insured receives coverage.

- A description of the carrier's method for resolving insured inquiries and complaints consistent with the regulation to be promulgated by the Department of Public Health, including a description of the internal grievance process required by section 13 of Chapter 176O, and the external review process established pursuant to section 14 of Chapter 176O.
- A description of the Office of Patient Protection, including its toll-free telephone number (1-800-436-7757), facsimile number (617-624-5046), and internet site (www.state.ma.us/dph/bhqm).
- A summary description of the utilization review procedures and quality assurance programs used by the carrier, including the carrier's toll-free telephone number that enables consumers to determine the status or outcome of utilization review decisions.
- A summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.
- If the carrier offers services through a network or through participating providers, the carrier must provide statements regarding continued treatment consistent with section 15 of Chapter 176O, including the following:
  - If the carrier allows or requires the designation of a primary care physician, a statement that the carrier will notify an insured at least 30 days before the disenrollment of the insured's primary care physician and will permit the insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by his or her primary care physician for at least 30 days after the physician is disenrolled, other than disenrollment for quality-related reasons or for fraud. The statement must also include a description of the procedure for choosing an alternative primary care physician.
  - A statement that the carrier will allow any insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with the provider,

[1] Please note that the use of the term 'insured' throughout this bulletin shall mean, "an enrollee, covered person, insured, member, policy holder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under the provision of M.G.L. c. 176O" as defined in M.G.L. c. 176O.

consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

- A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with that illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with the provider, consistent with the terms of the evidence of coverage, until the insured's death.
- A statement that the carrier will provide coverage for health services provided by a physician who is not a participating provider in the carrier's network for up to 30 days from the effective date of coverage to a new insured if the insured's employer only offers the insured a choice of carriers in which the physician is not a participating provider, and the physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician. With respect to a insured in her second or third trimester of pregnancy, this provision applies to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision applies to services rendered until death.
- If a carrier requires an insured to designate a primary care physician, a statement that the carrier will allow the primary care physician to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when the primary care physician determines that such referrals are appropriate, and 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 the health care services to be provided are consistent with the terms of the evidence of coverage.
- If the carrier requires a referral or prior authorization from a primary care physician for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care physician for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network: annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination; maternity care; and medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. The statement must also indicate that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician.

- A statement that the carrier will provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.
- A statement that physician profiling information, so-called, is available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.
- A summary description of the process by which clinical guidelines and utilization review criteria are developed.
- A statement that a carrier shall provide insureds, upon request, interpreter and translation services related to administrative procedures.

- A notice to insureds regarding emergency medical conditions that states all of the following:
    - Insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which, in the judgment of a prudent layperson, would require pre-hospital emergency services;
    - No insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;
    - No insured will be denied coverage for medical and transportation expenses incurred as a result of any such emergency medical condition; and
    - If the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

Carriers must submit revised contracts, policies, certificates and evidences of coverage, or relevant riders, endorsements, or amendments regarding these requirements to the Division in accordance with the provisions of their authorizing statutes. More details regarding compliance with these requirements will be set forth by regulation.

Provider Contracts

As noted in Bulletins 00-13 and 00-14, Chapter 141 required that carriers change their claims payment practices as of July 21, 2000 and creates new coverage requirements for emergency services rendered on and after January 1, 2001. In addition, Chapter 141 requires that contracts between carriers and health care providers meet the following requirements:

- As stated in section 4 of Chapter 176O, a carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients, or communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient. Nothing in this requirement, however, shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.
- As stated in section 5 of Chapter 176O, no contract between a carrier and a health care provider for the provision of services to insureds may require providers to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.
- As stated in section 10(a) of Chapter 176O, no contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care

professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract. In addition, health care professionals shall not profit from provision of covered services that are not medically necessary and appropriate, nor may carriers profit from denial or withholding of covered services that are medically necessary and appropriate. It should be noted, however, that nothing in this requirement shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with M.G.L. c. 176O § 10(b).

- As stated in section 10(b) of Chapter 176O, in order that patient care decisions are based on medical need and not on financial incentives, no carrier shall enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, revise the fee schedule in an existing contract with a physician or physician group that imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to stop loss protection, minimum patient population size for the physician or physician group, and identification of the health care services for which the physician or physician group is at risk.
- As stated in section 15(i) of Chapter 176O, a carrier shall provide health care providers applying to be participating providers who are denied such status with a written reason or reasons for denial of such application.
- As stated in section 15(j) of Chapter 176O, no carrier shall make a contract with a health care provider that includes a provision permitting termination without cause. In addition, a carrier must provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

In addition, carriers are reminded that M.G.L. c. 175, § 24B requires carriers to notify providers of modifications in payments or modifications in covered services and the effective date of the modifications. The notice must be provided 60 days before the effective date of such modification.

More details about compliance with these requirements will be set forth by regulation.

Utilization Review

Section 12 of Chapter 176O sets forth detailed requirements for utilization review that is conducted by carriers or entities with whom carriers contract. Carriers must comply with all such utilization review requirements effective January 1, 2001. Please note that Chapter 176O defines "utilization review" as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review." Thus, a carrier that employs any form of utilization review must comply with Chapter 176O.

Regulatory Process

As previously noted, Chapter 141 creates M.G.L. c. 176O (Chapter 176O) to be jointly enforced by the newly created Bureau of Managed Care (BMC) within the Division of Insurance and the Office of Patient Protection (OPP) within the Department of Public Health. Both agencies expect to promulgate regulations on an emergency basis to be effective on January 1, 2001. The regulations will address the provisions of Chapter 176O regarding the annual accreditation process for carriers, provider contracting, health plan disclosures, internal review and external review systems, medical necessity and access to certain providers in health plans. Both agencies plan to hold public hearings regarding their regulations in five locations across the Commonwealth during the first week of February 2001.

On December 8, 2000, the Attorney General, the Division of Insurance and the Department of Public Health held a public hearing for all interested parties regarding the exemption of certain health insurance carriers from the requirements for accreditation set forth in section 2 of Chapter 176O. Section 2(g) states that "[a] carrier shall be exempt from the accreditation if in the written opinion of the attorney general, the commissioner of insurance and the commissioner of public health, the health and safety of health care consumers would be materially jeopardized by requiring accreditation of the carrier. Before publishing such written exemption, the attorney general, the commissioner of insurance and the commissioner of public health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited. A carrier granted such an exemption shall be provisionally accredited and, during such provisional accreditation, shall be subject to review not less than every four months and will be subject to those requirements of Chapter 176O as deemed appropriate by the commissioner of insurance." The hearing was held to consider an exemption to permit existing carriers to continue to operate in the Commonwealth during the pendency of the initial accreditation process.

The attached written opinion, signed by the Attorney General, Commissioner of Insurance and Commissioner of Public Health, grants such an exemption. All carriers offering health coverage in Massachusetts as of December 8, 2000, are provisionally accredited. As noted in the opinion, such accreditation is provisional and based upon a carrier's compliance with all other provisions of Chapter 141.

Any questions regarding this bulletin should be directed to the Bureau of Managed Care at the Division of Insurance, at (617) 521-7372. The Division of Insurance regulations and hearing notices are posted on the Division's website at www.state.ma.us/doi.