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2006-03 Dental and Vision Service Plans

TO: **Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations**
FROM: **Julianne M. Bowler, Commissioner of Insurance**
DATE: **February 6, 2006**
RE: **Dental and Vision Service Plans**

Julianne M. Bowler

This bulletin is to inform carriers of certain changes to M.G.L. c. 176M, c. 176N, and c. 176O, found within Chapter 162 of the Acts of 2005, which became effective on January 1, 2006. These changes impact stand-alone and limited dental and vision coverage.

The effect of these changes is to exempt insured, limited scope vision-only benefit plans from the Nongroup health insurance and Portability of health insurance laws; and to exempt carriers that offer products solely for dental and vision coverage from the biennial accreditation process for insurance plans with managed care features. Carriers with dental-only or vision-only plans must, however, comply with certain sections of M.G.L. c. 176O. The provisions of M.G.L. c. 176O that now apply to dental-only and vision-only products are:

- A carrier may not refuse to contract with or compensate a provider solely because of the provider's good faith communications with or on behalf of a patient about the carrier's benefit or compensation plans. Carriers may, however, require providers to keep specific compensation terms confidential. (M.G.L. c. 176O, § 4).

- A contract between a carrier and a provider may not require the provider to indemnify the carrier in connection with any claim based on the carrier's policies, guidelines or actions. (M.G.L. c. 176O, § 5).

- A carrier must issue and deliver to at least one adult insured in each household, upon enrollment, (1) an evidence of coverage and any amendments thereto, (2) a summary of the information contained in the evidence of coverage, or (3) refer the insured to resources where the information can be accessed, including, but not limited to, an internet website. Specific requirements of what must be contained in the evidence of coverage are identified in the statute. (M.G.L. c. 176O, § 6(b)).

- A contract between a carrier and a provider group may not include any incentive plan that provides a financial inducement for a dental or vision care professional to restrict necessary covered services. (M.G.L. c. 176O, § 10).

- A carrier must give a provider, applying to be a participating provider, a written reason(s) for denying the application. (M.G.L. c. 176O, § 15(i)).

- A carrier must make interpreter and translation services available to insureds. (M.G.L. c. 176O, § 15(k)).

Please note that dental-only and vision-only products that have preferred provider provisions are still subject to M.G.L. c. 176I and 211 CMR 51.00 and should follow all requirements under that statute and regulation, including filing for approval as an insured preferred provider plan, filing material changes according to 211 CMR 51.06(1) and submitting annual reporting materials according to 211 CMR 51.06(2).

Carriers with dental-only and vision-only products that either employ utilization review or provide or arrange for services through provider networks and that have plans currently in the market should come into compliance with Chapter 162 as soon as possible. These carriers are to submit materials demonstrating compliance to the Bureau of Managed Care within the Division of Insurance no later than July 1, 2006.

This bulletin summarizes aspects of Chapter 162 of the Acts of 2005. Dental-only and vision-only carriers should not use this bulletin as a substitute for reading the law. Citations to the amended law have been provided for ease of research. Statutes and recent enactments may be found on the Web at http://www.mass.gov/legis. Any questions regarding this bulletin should be addressed to Nancy Schwartz, Director, Bureau of Managed Care at (617) 521-7347.