MASSACHUSETTS
HEALTH POLICY COMMISSION

2016 ANNUAL REPORT

Office of Patient Protection

Released March 2018

ABOUT THE HEALTH POLICY COMMISSION

The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform.

The agency's main responsibilities are managed by HPC staff and overseen by an 11-member board of commissioners. HPC staff and commissioners work collaboratively to monitor and improve the performance of the health care system. Key activities include setting the health care cost growth benchmark; setting and monitoring provider and payer performance relative to the health care cost growth benchmark; creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs; analyzing the impact of health care market transactions on cost, quality, and access; and investing in community health care delivery and innovations.

MISSION STATEMENT

The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs. The HPC's goal is better health and better care – at a lower cost – across the Commonwealth.

HISTORY OF THE OFFICE OF PATIENT PROTECTION

Prior to 1990, only two states had external review programs for denials of health insurance claims. In 1998, former Governor Paul Cellucci signed Executive Order No. 405 to establish managed care protections for consumers. A section of this executive order created an Office of the Managed Care Ombudsman. Two years later, the Office of Patient Protection was established through Chapter 141 of the Acts of 2000, a law that created new protections for health insurance consumers. During January 2001, the Office of the Managed Care Ombudsman merged with OPP. OPP operated within the Department of Public Health from 2000 until Chapter 224 of the Acts of 2012 created the Health Policy Commission and transferred the Office of Patient Protection from the Department of Public Health to the Health Policy Commission, effective April 20, 2013.

INTRODUCTION

Entering its sixteenth year of operation, the Office of Patient Protection (OPP), a program within the Massachusetts Health Policy Commission (HPC), is responsible for regulating and administering certain health insurance consumer protections for the Commonwealth. It is a resource for individuals who want to become more informed and empowered health care consumers. This annual report provides a comprehensive overview of activities of the Office.

KEY RESPONSIBILITIES OF THE OFFICE OF PATIENT PROTECTION

OPP safeguards the rights of health insurance consumers by regulating the internal grievance process and administering external reviews for consumers with fully-insured Massachusetts health plans, administering health insurance enrollment waivers, and providing information and education about health insurance concerns to the public. The core responsibilities of OPP are:

- Regulating the internal review process for consumers who wish to challenge denials of coverage by health plans
- Regulating and administering the external review process for consumers who seek an independent appeal to challenge adverse determinations issued by health plans
- Administering an enrollment waiver process for consumers who wish to purchase non-group health insurance
- Regulating appeals processes for commercially insured patients of Risk-bearing Provider Organizations and HPC-certified Accountable Care Organizations
- Examining, analyzing, and reporting on certain information and data received annually from Massachusetts health plans
- Providing training, education, and responding to consumer inquiries about health insurance appeal rights, open enrollment waivers, and other issues related to health coverage and services

NOTABLE UPDATES IN 2016

Revised Regulation: OPP revised its Health Insurance Consumer Protection regulation, 958 CMR 3.000, to incorporate additional reporting requirements for fully-insured health plans. Chapter 52 of the Acts of 2016 amended M.G.L. c. 176O, sec. 7 to add new health plan reporting requirements on claims and claim denials. The new reporting requirements will provide greater transparency, broaden the data currently reported to OPP, and supplement information submitted to DOI. The final regulation was issued in early 2017. Carriers will report this additional information for 2017 (reported in July, 2018).

Issued Guidance: OPP issued interim guidance advising Risk-bearing Provider Organizations (RBPOs) certified by the Division of Insurance of a new legal requirement under Massachusetts law to establish an appeals process to address patient complaints. This interim guidance also applied to provider organizations seeking certification as Accountable Care Organizations by the HPC. Statutory requirements, pursuant to M.G.L. c. 176O, sec. 24, are similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations but apply to provider determinations on referrals, appropriate treatments, and timely access to care. OPP held two information sessions and released a Frequently Asked Questions document to aid RBPOs' implementation of the Interim Guidance. RBPOs began implementing internal appeals procedures in October 2016.

OPP Operations: OPP provides a "no wrong door" approach for consumers and other stakeholders requesting assistance with health care and coverage concerns. To that end, OPP staff continues to implement improvements to internal operations while strengthening statewide stakeholder relations. Throughout the year, the team responded to over 1,360 inquiries via its toll-free hotline. As in past years, most callers had inquiries regarding their rights to appeal a denial of coverage by health plans. In 2016, OPP experienced a transition in leadership, with a new Director, Steven Belec, joining OPP in March.

ENROLLMENT WAIVERS

Federal and state law limit when individuals and families can buy certain health insurance plans. Most Massachusetts consumers must buy insurance during a designated open enrollment period. Massachusetts residents who missed the previous open enrollment period, and have not experienced a qualifying life event, may qualify for a waiver of the open enrollment period if they meet certain criteria. The Office of Patient Protection reviews waiver requests

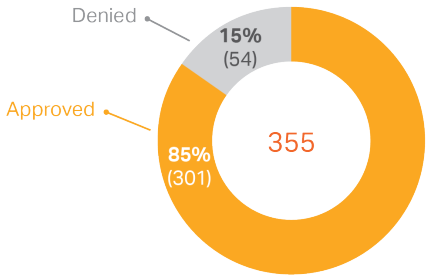
and typically grants open enrollment waivers to individuals and families who:

- Are uninsured and did not intentionally forgo enrollment in health insurance, or
- Lost insurance coverage but did not find out until after 60 days had passed

2016 ENROLLMENT WAIVER DATA

During 2016, the Office of Patient Protection received 355 (**Figure 1**) requests for waivers from Massachusetts residents seeking to buy insurance from the Health Connector or directly from an insurance company or insurance agent. Upon review, OPP issued 301 waivers to eligible applicants or 85% of all received requests. OPP also provided guidance to consumers who had difficulty enrolling in a health plan. Since the waiver process cannot resolve all health plan enrollment issues for uninsured consumers, OPP staff triaged concerns and provided information and referrals to other agencies or organizations as needed.

FIGURE 1



Year	Total Waiver Applications
2011	276
2012	576
2013	416
2014	316
2015	562
2016	355

Source: 2011-2016 Office of Patient Protection Waiver Data

i M.G.L. c. 176O §§ 13-14

HEALTH INSURANCE APPEALS

Under Massachusetts law,[i] health care consumers have the right to appeal certain decisions by their health plans. This essential consumer protection provides an economical and fair process to resolve disputes between insureds and their health plan. These laws apply to individuals with "fully-insured" Massachusetts health plans (see Glossary for definitions). Consumers with other types of health plans, including self-insured plans, MassHealth (Medicaid), or Medicare, have different appeal rights under other state or federal laws. This external review process can lead to health care cost savings by identifying instances where health care services should not be covered under a plan's benefit package when they are not medically necessary.

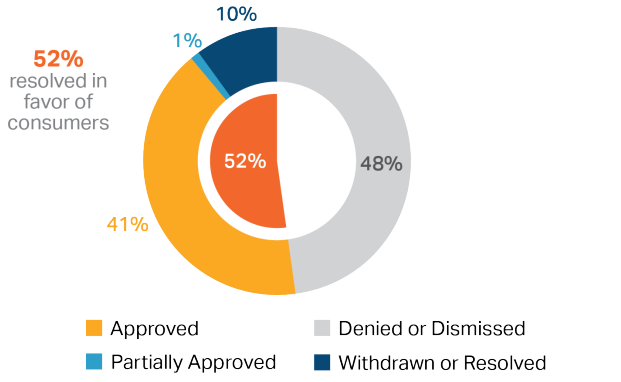
INTERNAL REVIEW

When an insurer informs a consumer that the health plan will not pay for or cover the consumer's medical or behavioral health treatment, the consumer may appeal that decision by first contacting the health plan. This first appeal, often called a member grievance, is an internal review by the health plan. The consumer may seek an expedited internal review for urgent matters. Otherwise, the health plan must respond to the consumer within 30 business days, unless both parties agree, in writing, to an extension. The health plan may uphold the original decision, or it may change its decision and cover all or part of the insured's treatment.

2016 INTERNAL REVIEW DATA

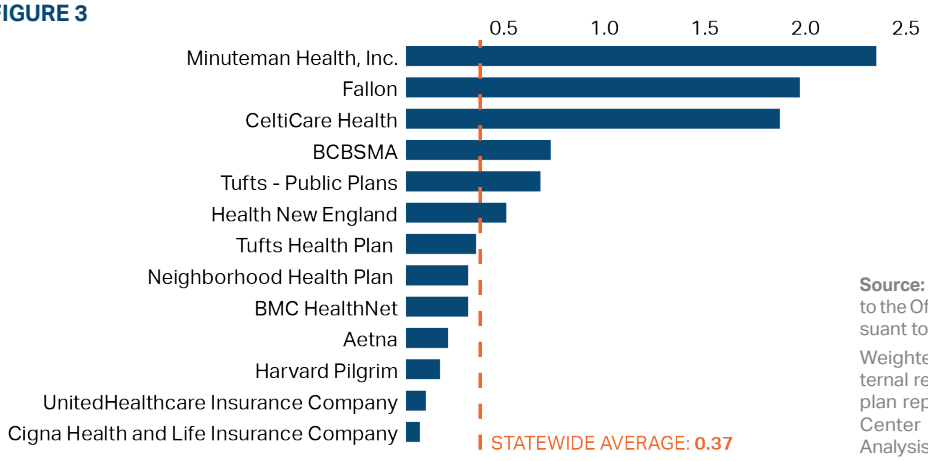
During 2016, Massachusetts health insurance companies reported 15,261 member grievances (**Figure 2**). These grievances include many different types of member complaints, such as disputes over coverage for treatment or cost-sharing.

FIGURE 2



Source: 2016 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

FIGURE 3



Source: 2016 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600.

Weighted by dividing number of internal reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2015

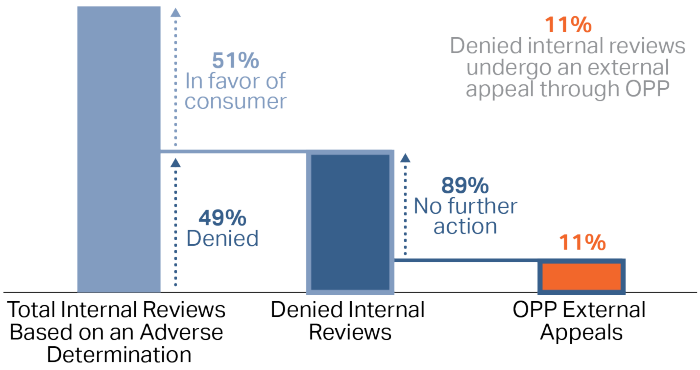
Figure 3 shows the member grievances reported by each health insurance company that provided fully-insured coverage in Massachusetts during 2016. As in past years, insurers with more members have more appeals. In order to compare health insurance company practices, OPP also analyzed the number of grievances filed per number of health plan members, to come up with a "weighted average" that gives a better indication of which insurers have the highest numbers of grievances relative to their total membership.

Under current OPP regulations, health plans report detailed information about the types and outcomes of member grievances received. For 2016, health plans reported the following figures:

- **Member grievances:** Health insurers resolved 52% or 7,872 of all member grievances fully or partly in favor of the member
- **Medical necessity denials:** 6,037 or 40% of internal grievances resulted from adverse determinations by the carrier, which are denials of coverage based on health plan medical necessity decisions.
- **Behavioral Health:** Of the 6,037 grievances based on medical necessity, 16% or 975 involved behavioral health treatment.
- **Pursuing external review:** About 11% of patients or consumers sought an independent external review of the health plan's final adverse determination. See **Figure 4**. While this number may seem low, it does indicate that a significant portion of consumers are aware of their appeal rights and choose to exercise them, and yet some opportunities for consumer engagement remain. OPP plans to increase outreach and education initiatives to bolster awareness of patient appeal rights and inform stakeholders of the resources available through OPP.

ii 958 CMR 3.020.

FIGURE 4



Source: 2016 Office of Patient Protection external review data; 2016 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

In Favor of Consumer includes Approved, Partially Approved, and Withdrawn or Resolved

WHAT IS MEDICAL NECESSITY? Health insurance companies that are licensed to do business in Massachusetts must pay for medical services and treatments that are covered benefits under the health plan and that are medically necessary. Health insurers may develop their own standards for deciding when care is medically necessary. Massachusetts law defines medical necessity in the following way:

Medical Necessity or **Medically Necessary** means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;

b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or

c) for services and interventions not in widespread use, is based on scientific evidence.[ii]

EXTERNAL REVIEW

After a health plan's internal appeals process is exhausted, the insurance provider is required by law to allow for an external appeal. The process offers health care consumers the opportunity to obtain an independent review when a health plan denies coverage as not medically necessary or as experimental or investigational; such notice is often referred to as a final adverse determination. If a consumer, or authorized representative, pursues an internal review and the health insurer upholds its original decision, the consumer may have the right to pursue an external review. An external review is a second level of appeal, conducted by an organization independent from the consumer's health plan. Health insurance companies may deny services prospectively (such as prior authorizations), retrospectively, or concurrently (during the course of treatment). External review is only available when the health plan's determination was based on whether the specific treatment or service at issue was medically necessary.

ELIGIBILITY FOR EXTERNAL REVIEW THROUGH THE OFFICE OF PATIENT PROTECTION

Requests must be eligible for external review. An insurance dispute is usually eligible for external review through OPP if all of the following are met:

- The health insurance company is licensed in the Commonwealth
- The insurance product is a fully-insured health insurance plan
- The patient's request for external review includes one of these:
  - A final adverse determination, OR
  - An adverse determination, if the patient is seeking an expedited internal review and expedited external review at the same time, OR
  - A written confirmation that insurance company has waived internal review
- The final adverse determination or adverse determination is based on medical necessity
- Request for external review filed with OPP within four (4) months of the date from when the patient received the final adverse determination (final denial by health plan).
- Request for external review is in writing and on the external review request form issued by OPP

OPP makes every effort to assist consumers in finalizing applications that are missing necessary information in their filed request. A request is considered incomplete if requisite application components are missing like attestations or signatures. The most common reasons of ineligible applications in 2016 were: the applicant is a member of a self-insured plan; the dispute involves a benefit that is specifically excluded from coverage; and the application was not submitted to OPP in a timely manner.

EXTERNAL REVIEW PROCESS

The Office of Patient Protection administers the Massachusetts external review process for consumers with fully insured health plans. In most cases, a consumer must pursue an internal review or member grievance first. A consumer seeking an external review must file an external review request with OPP within four months after receiving this second denial, or the "final adverse determination," from the insurance company.

When OPP receives an eligible request for external review, the request is randomly assigned to one of three external review agencies, also known as independent review organizations, which have agreed to avoid conflicts of interest. The Health Policy Commission contracts with these three nationally accredited, independent external review agencies. These external review agencies are not government agencies. They are private companies with panels of doctors and medical experts who work in different fields and are located throughout the country. During 2016, the HPC contracted with:

- Independent Medical Experts Consulting Services, Inc. (IMEDECS), based in Lansdale, Pennsylvania
- Island Peer Review Organization (IPRO), based in Lake Success, New York
- ProPeer Resources, Inc., based in Centerville, Utah

After receiving the OPP case file (which includes the external review request form, denial notices from the insurer, and any additional information submitted by the patient), the external review agency assigns it to one or more of its medical experts who practice in the same or similar specialty as the service in dispute. The medical expert then reviews the information submitted by the insurance company and the patient, and reaches an independent conclusion about whether the treatment or service is medically necessary for the patient.

In accordance with state law, the external review agency issues its decision within 45 days for standard external reviews and within 72 hours for expedited external reviews. The decision of the external review agency is final and binding, though other legal rights apart from OPP's external review process may be available.

The consumer who requests external review usually pays a $25 fee toward the cost of the review. Upon request, OPP may waive the $25 fee due to financial hardship; no consumer is required to pay more than $75 in fees per year. If a consumer prevails on external review and the decision is overturned, OPP refunds the $25 fee to the consumer. The insurer pays the external review agency for most or all of the external review, a cost which can range from $600 to $2,100 depending on the time frame for the review, type of review, and the number of reviewers needed.

In making its decision, the external clinical reviewer considers the determination of the health plan, medical records of the patient, comments from a treating provider, and other pertinent documents to determine medical necessity. An external appeal decision is issued to all parties in writing and is subject to the terms and conditions of the insured's coverage with the health plan, such as cost sharing requirements, or maximum benefit limitations.

2016 EXTERNAL REVIEW DATA

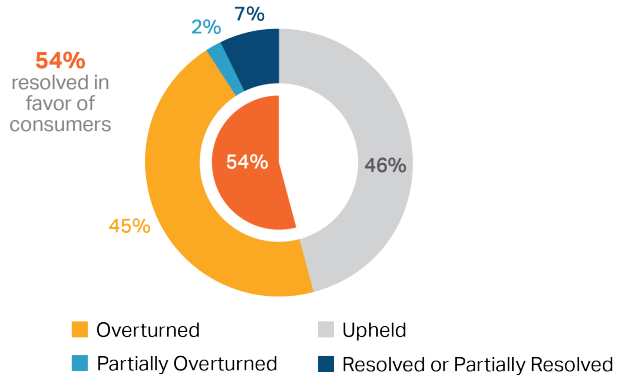
For each calendar year, the HPC analyzes overall external review data and further delineates its analysis by medical/surgical and behavioral health data.

EXTERNAL REVIEW CASES AND RESULTS FOR 2016

During 2016, OPP screened 308 external review requests for eligibility. 237 or 77% of these requests were deemed eligible for external review. Of the eligible cases, 47.7% were overturned in whole or in part or modified by the external review agency in favor of the patient. Approximately 6.8% of the cases that would have been eligible were resolved between the patient and the insurer or withdrawn before a final determination was issued. The external review agencies upheld the remainder of the cases, which accounted for 45.6% of cases eligible for review. Comparable with prior years, the vast majority of external reviews have involved disputes between consumers and their health plans over whether treatments were medically necessary. A small number of requests, 3.4%, involved denials of coverage by health plans on the grounds that the treatments were experimental or investigational.

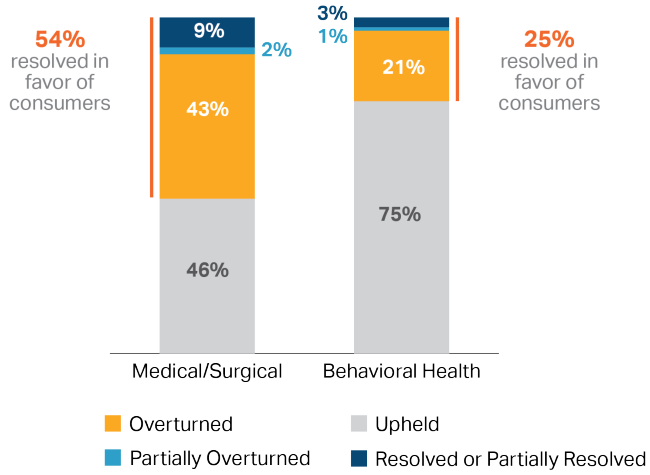
Figure 5 illustrates the dispositions or results for all eligible external reviews filed during 2016. **Figure 6** breaks down the total number of external reviews into two categories: medical or surgical care and behavioral health.

FIGURE 5



Source: 2016 Office of Patient Protection external review data

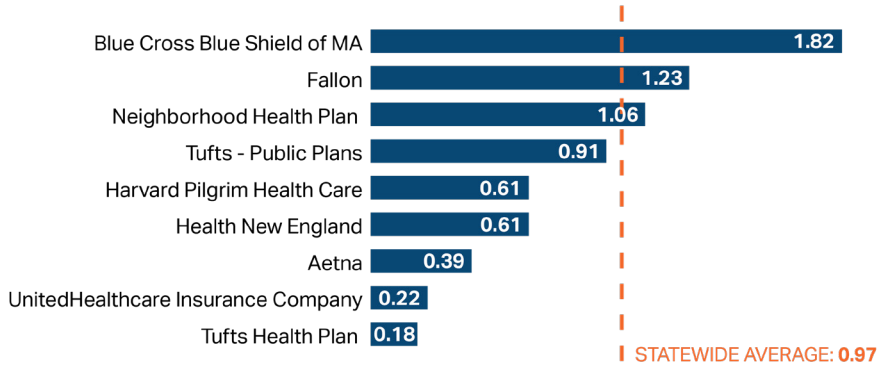
FIGURE 6



Source: 2016 Office of Patient Protection external review data

Figure 7 compares the frequency of eligible external reviews for each health plan. This number is calculated by adjusting the total number of external reviews for each plan by the number of members reported by each health plan in 2016, the most recent information publicly available. This analysis identifies a statewide average for the number of external

FIGURE 7



Note: Weighted by dividing number of external reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2016

Source: 2016 Office of Patient Protection external review data, Member months from Center for Health Information and Analysis, 2016

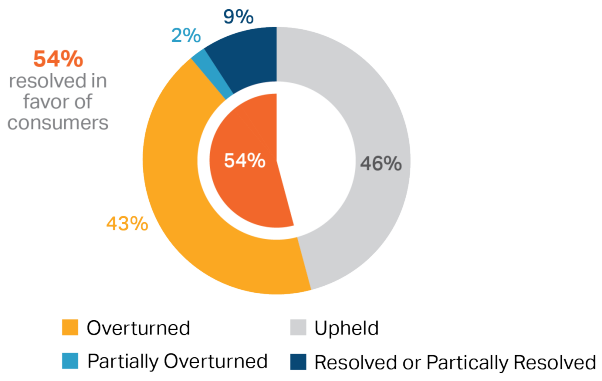
reviews filed by all fully-insured health plan members. Of the large health plans identified in **Figure 7**, three had a rate of external review above the statewide average, with Blue Cross Blue Shield of Massachusetts reporting the highest proportion.

MEDICAL/SURGICAL DATA

OPP received 166 eligible external review requests involving medical or surgical services. This category encompasses appeals involving a broad range of medical care, including imaging, lab testing, pharmacy requests, and infertility treatment. External review data for behavioral health services are explored further below.

In 2016, 46% of external reviews involving medical or surgical treatment upheld the decision of the health insurer and 54% of reviews were resolved either fully or partially in favor of the patient (**Figure 8**). The remaining matters were resolved prior to an issued decision.

FIGURE 8



Outcomes of eligible external reviews for medical/surgical service requests in 2016.

Source: 2016 Office of Patient Protection external review data

The most common medical/surgical review requests were in the categories of outpatient care and pharmacy. OPP received 68 external review requests regarding outpatient medical/surgical care including surgeries, medical visits, and rehabilitation services, 45 of which were eligible for external review.

Additionally, 49 requests were received for pharmacy treatments, of which 38 were eligible for external review. Of the 38 matters in this category that were reviewed, 21 were overturned or partially overturned by the external review agency.

During 2016, OPP received 19 external review requests involving infertility treatment. Out of the 17 eligible cases, 8 were upheld by the external review agency and 9 were overturned.

EXPERIMENTAL AND INVESTIGATIONAL SERVICES

OPP provides consumers with the right to obtain an independent review by clinical experts when health plans consider services to be experimental or investigational. In 2016, OPP received approximately 8 eligible external review requests involving services deemed to be experimental or investigational by the insurance companies. These types of requests included, for example, diagnostic procedures, off-label medication requests, and non-standard surgical procedures or treatments. Of the matters sent for review, 2 of the requests were overturned in favor of the patient and 5 were upheld (1 was withdrawn prior to the issuance of a decision). Provided that the absolute number of OPP cases is small, it is difficult to draw comparisons based on such a small sample size.

OUT OF NETWORK COVERAGE REQUESTS

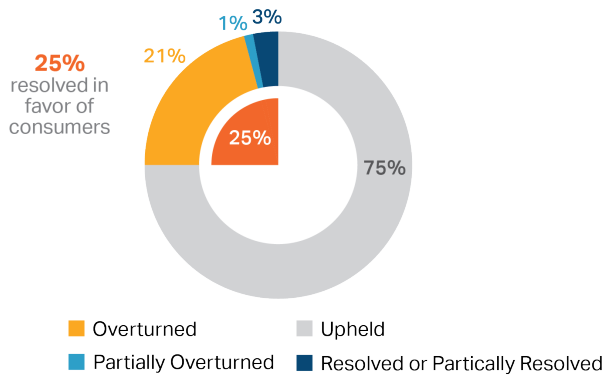
In some instances, a consumer has the right to appeal a denial of coverage for treatment by a provider who is outside of the insurer's network. If the treatment is a covered service, and if the insurer denied coverage because it was not medically necessary to receive the services from an out of network provider, then the consumer may request external review. OPP determines whether such matters are eligible for review on a case-by-case basis. If eligible, the reviewer then decides whether the treatment is medically necessary and if so, could any in-network provider perform the procedure or provide the service at issue.

During 2016, OPP received 22 requests for external review involving coverage for an out of network provider. Only 8 of these were eligible for external review and 5 were resolved in favor of the patient.

BEHAVIORAL HEALTH

Behavioral health cases, which include treatment for mental health conditions, substance use disorders, and some developmental disabilities, represented a significant proportion of external review cases received by OPP during 2016 (**Figure 9**).

FIGURE 9



Eligible external reviews related to behavioral health treatment by outcome, 2016

Source: 2016 Office of Patient Protection external review data

OPP received 90 requests for external review of behavioral health services during 2016, and 80 of these were eligible for external review.

- **Mental health treatment:** Of the eligible cases, OPP received 45 requests for mental health treatment. Inpatient mental health care represents the largest subcategory, with 16 eligible requests for external review.
- **Substance use disorder treatment:** OPP received 23 eligible requests for treatment related to substance use disorders; 15 of which were for residential substance use disorder treatment.

About one-quarter of the eligible behavioral health cases were resolved in the patient's favor. Of the 23 eligible cases regarding substance use disorder, 12 were overturned by an independent medical reviewer because care was not found to be medically necessary.

HEALTH INSURANCE APPEALS OVERVIEW

In general, a consumer who receives an adverse determination from an insurance company, denying coverage based on medical necessity grounds, has a significant chance of modifying or overturning the decision through the appeals process. According to figures reported to OPP by health plans, 50.5% of members who received adverse determinations from their health plans were able to have their disputes partially or fully resolved in their favor through the internal review or external review process.

The numbers of external review requests filed during 2016, and the numbers of reviews deemed eligible, were largely consistent with recent years. Additionally, the data suggests that there is parity in the final dispositions of OPP administered external reviews for both behavioral health and medical/surgical procedures. In 2016, 25% of behavioral health external reviews were overturned, partially overturned, resolved or partly resolved in favor of the consumer which is generally consistent with prior trends.

HEALTH CARE CONSUMER PROTECTIONS

HEALTH PLAN REPORTING

Massachusetts fully-insured health plans submit annual reports to the Office of Patient Protection, providing information about the following:

- Internal reviews
- External reviews
- Sources of information about consumer satisfaction
- Rates of provider disenrollment and reasons for disenrollment
- Medical loss ratio
- Other health plan information

OPP works with other agencies and seeks input from stakeholders, like health insurance companies and consumer groups, to implement Massachusetts health insurance laws. Where inter-agency questions or concerns arise, OPP works closely with the Massachusetts Division of Insurance, the Office of the Attorney General, the Health Connector, the Office of Medicaid, and other state and federal agencies to address concerns, minimize duplicative efforts, reduce regulatory burden, and ensure compliance.

CONSUMER INFORMATION AND ASSISTANCE

The Office of Patient Protection serves as a resource for consumers, through our hotline, website, and educational guides. OPP assists with questions about health insurance appeals, enrollment waivers, and other health insurance problems through our hotline, at 800-436-7757. Telephone translation services are available for callers who speak non-English languages or for those who are hearing impaired; staff is also accessible by email or by fax. On our website at www.mass.gov/hpc/opp, consumers can find relevant forms in English and Spanish, instructions for pursuing an external review or requesting an enrollment waiver, data, reports, and a comprehensive list of informational tools and resources to assist with matters related to health care coverage and access to care.

TRAINING AND OUTREACH

OPP welcomes requests for informational presentations from consumer organizations, health care providers, government agencies, and other interested groups. Staff is available to provide trainings and to answer questions. To request a training, contact OPP at HPC-OPP@state.ma.us or at 1-800-436-7757.

APPEALS PROCESS FOR PATIENTS OF RISK-BEARING PROVIDER ORGANIZATIONS (RBPO) AND ACCOUNTABLE CARE ORGANIZATIONS (ACO)

OPP also has authority to administer a new consumer protection included in Chapter 224 of the Acts of 2012 for patients of RBPOs and HPC-certified ACOs. This new consumer protection provides an opportunity for patients attributed to a RBPO or ACO to appeal provider determinations about referral restrictions or other potential limitations of care. During 2016, OPP engaged with stakeholders to gather information in support of regulatory development, resulting in Interim Guidance released in May, 2016 (HPC-OPP-2016-1). RBPOs began implementing internal appeals procedures in October 2016.

Since its inception, the Office of Patient Protection has worked effectively to safeguard health care consumer protections in the Commonwealth. OPP has continued to solicit and act on feedback and promote awareness of external appeal and waiver rights. OPP strives to address each inquiry, waiver, and appeal in a fair and consistent manner. OPP's efforts contribute to the provision of high quality patient care while advancing a more transparent, accountable, and innovative health care system.

> *"I got great news yesterday… (the patient) was transferred from where he was to the proper facility… and I could not be more grateful, and appreciative, and overwhelmed with happiness. Thank you so so so much for all of your wonderful calm, supportive, nothing could phase you attitude to help me with through this process. I wanted to make sure people know how wonderful the Office is."*
>
> **-MASSACHUSETTS HEALTH CARE CONSUMER**

GLOSSARY

FULLY-INSURED

A health insurance plan purchased by an individual, a family, an employer, or another entity. The purchaser of the health insurance plan pays premiums to the insurance company and, in return, the insurance company pays the claims for certain health care services. Fully-insured plans can be regulated by the state government. This is also referred to as fully-funded.

INDEPENDENT REVIEW ORGANIZATION

An independent third-party medical review resource that provides objective medical determinations based on evidence that includes medical reports, health plan guidelines, and evidence-based criteria. Each review organization offers a panel of clinical providers to review appeals fairly and impartially. IROs are required to be accredited by URAC or other nationally recognized accrediting entity.

HEALTH PLAN

In this report, a "health plan" refers to an insurance product or insurance plan offered by a health insurance company.

MEDICAL NECESSITY OR MEDICALLY NECESSARY

Refers to health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

- is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, is based on scientific evidence.

NON-GROUP INSURANCE

Non-group insurance means health insurance that you buy for yourself or your family from the Health Connector or from an insurance company or insurance agent.

OPEN ENROLLMENT

Under Massachusetts and federal law there are only certain times during the year when individuals and families may buy non-group health insurance coverage. The time when individuals and families can apply – the time when health insurers open plans to new members – is called "open enrollment." This is similar to the process employers use to allow their employees to sign up or change plans during specific times.

SELF-INSURED/ SELF-FUNDED

Under a self-insured or self-funded plan, your employer pays the costs for its employees' health care directly instead of paying premiums to buy health insurance. Some self-insured employers hire insurance companies to process the paperwork and it may be difficult to discern if a plan is self-funded. Contact your employer to find out if your plan is self-insured. Self-insured plans are usually regulated by the federal government and governed by "ERISA" or the Employee Retirement Income Security Act of 1974.

ACKNOWLEDGMENTS

OPP would like to acknowledge its staff, Stephanie Carter, Program Coordinator, and Eric Rollins, Program Associate, who assisted with this report under the guidance of Steven Belec, Director.

HPC staff made significant contributions to the preparation of this report, including Rebecca Balder, Coleen Elstermeyer, Lois Johnson, Kelly Mercer, and Nancy Ryan.

The HPC acknowledges the efforts of other government agencies in the development of this report, including the Center for Health Information and Analysis and the Department of Public Health.

The HPC would like to thank the insurance companies that submitted information included in this report. The HPC acknowledges the critical input of both consumers and marketplace stakeholders, and hopes that this report provides useful information for navigating health insurance consumer protections in Massachusetts.

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