COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • Toll-free (877) 563-4467
http://www.mass.gov/doi

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

MIKE KENNEALY
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

EDWARD A. PALLESCHI
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

GARY D. ANDERSON
COMMISSIONER OF INSURANCE

Filing Guidance Notice 2021 – C
Accident and Sickness Insurance

TO: All Carriers Offering Individual and Group Medicare Supplement Policies ("Carriers")

FROM: Niels Puetthoff, Director, Bureau of Managed Care

DATE: May 18, 2021

RE: Guidelines for Submitting Filings with Proposed Innovative Preventive Care Benefits to Medicare Supplement Products

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The purpose of this notice is for the Division of Insurance ("Division") to provide guidance as Carriers offering Medicare Supplement products consider the submission of filings to add innovative benefits, as permitted under 211 CMR 71.00 ("Medicare Supplement Insurance to Facilitate the Implementation of M.G.L. c. 176K and Section 1882 of the Federal Social Security Act"). As noted within 211 CMR 71.09, "The new or innovative benefits may include benefits that are appropriate to Medicare Supplement Insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare Supplement Insurance Policies...[and o]nly those new and innovative benefits specified in 211 CMR 71.09 and any other new or innovative benefits approved by the Commissioner may be so offered."

Within 211 CMR 71.09(4), it is noted that Carriers "providing Medicare Supplement Insurance may provide alternate innovative benefits consisting of the innovative preventive care benefit described in 211 CMR 71.09(4)(a)...provided, that each Issuer may offer only one combination of the benefits described in 211 CMR 71.09(4)(a)…for each type of Medicare Supplement Insurance Policy." The benefits referenced in 211 CMR 71.09(4)(a) include the following:

1. Preventive Vision Care Benefits;
2. Dental Care Benefits;
3. Preventive Hearing Care Benefits; and
4. Fitness or Weight Loss Program Benefits.

It is further noted that, for each of the noted benefit options, a Carrier may limit benefits to those received from a provider "with whom it has an agreement; provided that such limitation does not significantly reduce the availability of benefits under the Policy." When submitting any filing that limits benefits to providers with whom a Carrier has an agreement, a Carrier will be expected to

submit materials that illustrate: the array of providers with whom a Carrier has an agreement, where the noted providers are available, and a template of the agreement(s) that the Carrier may have with the noted providers.

Agreements with Providers

There are provisions within M.G.L. c. 176K and 211 CMR 71.21 for Medicare Select policies that condition "the payment or benefits, in whole or in part, on the use of Network Providers." However, a plan's use of a network solely for the purposes of providing these innovative preventive care benefits will not indicate that a product is a Medicare Select policy, since providers covered by these innovative preventive care benefits are providers that are not covered under Medicare or traditional Medicare Supplement policies. Nonetheless, Medicare Supplement products are offered throughout Massachusetts to Medicare eligible persons to obtain benefits for services provided within their own community. Thus, the Division expects that innovative preventive care benefits that are limited to those benefits received from a provider with whom the Carrier has an agreement will have providers available to provide those innovative preventive care benefits throughout the Commonwealth of Massachusetts, and Carriers will be subject to relevant network adequacy provisions of M.G.L. c. 176O and 211 CMR 52.00 ("Managed Care Consumer Protections and Accreditation of Carriers").

Within filings, Carriers should demonstrate in either of the following ways that they have made innovative preventive care benefits available throughout the Commonwealth:

(a) Any Willing Provider Networks: Carriers will be expected to submit a plan that illustrates the following:
    1. The Carrier or its subcontracting organization has "any willing provider" contracts" that enable any Massachusetts licensed provider of the innovative preventive care service to join by agreeing to the terms of the contract.
    2. The provider contracts prohibit willing providers from billing or otherwise seeking reimbursement from or recourse against any Individual Insured other than for supplemental charges or cost-sharing amounts, and
    3. The willing providers who join such contracts are adequately available to eligible Medicare individuals throughout the Commonwealth. In presenting information to illustrate that providers are adequately available, Carriers must take into account both the distance eligible Medicare individuals may need to travel to appointments and the availability of public transportation to visit any willing Network Providers.

(b) Restricted Provider Networks: Demonstrate that the Carrier has satisfied the consumer protection standards that are part of 211 CMR 71.21 for restricted provider networks. Carriers will be expected to submit a plan that illustrates the following:
    1. The number of Network Providers is sufficient, with respect to current and expected Policyholders, taking into account both the distance eligible Medicare individuals may need to travel to appointments and the availability of public transportation to visit any willing Network Providers,
    2. The Carrier or its subcontracting organization has written agreements with Network Providers describing specific responsibilities.
    3. In the case of covered services that are subject to a Restricted Network Provision and are provided on a prepaid basis, the Carrier or its subcontracting organization has written agreements with Network Providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any Individual Insured other than for supplemental charges or cost-sharing amounts as

stated in the innovative preventive care benefit descriptive materials.

4. A map providing a clear description of the locations of Network Providers within Massachusetts.
5. A description of the grievance procedure to be utilized if there are complaints associated with any Network Provider.
6. A description of the quality assurance program, including:
   i. The formal organizational structure;
   ii. The written criteria for selection, retention and removal of Network Providers; and
   iii. The procedures for evaluating quality of care provided by Network Providers, and the process to initiate corrective action when warranted.
7. A list and description, by specialty, of the Network Providers.
8. Copies of written information proposed to be used by the Carrier to allow for services from non-Network Providers when not reasonable to access a network provider.
9. Information to be used to make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select Policy to each applicant. This disclosure shall include at least the following:
   i. A description (including address, phone number, and hours of operation) of the Network Providers, including primary care providers, specialty providers, hospitals, and other providers;
   ii. A description of the Carrier's or its subcontracting organization's quality assurance program and grievance procedure; and
   iii. Application to be signed and dated by the applicant prior to the sale of a Medicare Supplement product that includes innovative preventive care benefits, including appropriate disclosures such that the applicant understands that benefits are only available from Network Providers, and which explain the procedures for resolving Insureds' complaints and written grievances.

<u>Changes to Provider Networks</u>

The Division will expect Carriers who offer innovative preventive care benefits that limit services to those providers with whom the Carrier has an agreement to notify the Division regarding material changes to their networks and how they will make services available from non-contracted providers if the network does not provide adequate access to care in any part of the Commonwealth. The Division will also expect that Carriers make a filing annually by no later than October 1st of each year with a list of providers in the plan's network.

Questions about this filing guidance notice should be directed to Niels Puetthoff, Director of the Bureau of Managed Care, at (617) 521-7326 or at Niels.Puetthoff@mass.gov.