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DIVISION OF INSURANCE
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HEALTH COVERAGE

Filing Guidance Notice: 2025-M

TO: Insurance Issuers Offering and/or Renewing Insured Health and Dental Plans in the Massachusetts Merged Small Group/Individual Market to be effective January 1, 2026

FROM: Niels Puetthoff, Director, Bureau of Managed Care

DATE: April 8, 2025

RE: Submission of Policy Form Materials for the Review of Merged Market Health and Dental Benefit Plans Proposed to be Available as of January 2026

The purpose of this Notice is to provide guidance on filing policy forms with the Massachusetts Division of Insurance ("Division") necessary for reviewing coverage intended to be issued and/or renewed in the Massachusetts merged small group/individual market as of January 1, 2026.

The guidance provided in this notice applies to all insured health benefit plans and dental plans offered and/or renewed in the merged market, including the Qualified Health Plans ("QHPs") and Qualified Dental Plans ("QDPs") that must be certified by the Commonwealth Health Insurance Connector Authority ("the Health Connector") for offer through the Massachusetts State-Based Market Exchange.

I. General Information:

Pursuant to Section 1302 of the Patient Protection and Affordable Care Act and federal rule 45 CFR 156.100, the Division of Insurance selected the HMO Blue New England $2000 Deductible Plan ("HMO Blue New England") offered by Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. as its 2017 and subsequent years thereafter base-benchmark plan, supplemented with the FEDVIP High Option plan for pediatric vision services and the Massachusetts CHIP plan for pediatric dental services. This continues to be the benchmark plan for year PY 2026 and going forward.

All merged small group/individual market health benefit plans offered and/or renewed in 2026 should include all Essential Health Benefits ("EHBs") as further outlined on the Division's website https://www.mass.gov/service-details/essential-health-benefit-benchmark-plan and must meet actuarial value levels associated with "metallic tiers" established under rules developed by the federal Secretary of Health and Human Services, as calculated using the most recently available federal actuarial value calculator.

Massachusetts Issuers must cover all mandated benefits and medications, in addition to the EHBs and Preferred Pharmacy Drug List ("PDL") as outlined on the Division's website. https://www.mass.gov/doc/mandatory-benefits-guide/download

II. CHANGES FOR PY 2026

A. Network Adequacy

Starting with PY 2026, health carriers issuing or renewing health plans in the merged market, and dental carriers issuing or renewing QDPs, will be required to follow federal standards for adequacy of networks. For details of the provider categories and the time and distance standards, please see the attached Addendum A.

Carriers are expected to work with the Division and Health Connector's vendor, Quest Analytics (Quest), to submit provider information directly to Quest, including any templates that are deemed to be necessary for products offered for PY 2026 in the merged market. Each Carrier will receive separate communication from the Division no later than April 11, 2025 indicating which documents to submit to Quest. All identified documents to be sent to Quest will be the same versions as carriers are submitting to the SERFF binders and are due to Quest **by May 15, 2025.**

B. Evidences of Coverage

1. Carriers are expected to submit final "clean" versions of all Evidences of Coverage, along with any corresponding Prescription Drug Riders (if separate), and Schedules of Benefit.
2. Carriers are expected to submit any redlined versions of Evidences of Coverage, any corresponding Prescription Drug Riders (if separate), and Schedules of Benefit, noting any changes from PY 2025 versions.
3. Carriers are expected to comply with the requirements of recent Division Filing Guidance Notices by incorporating any new language and/or material changes within their Evidences of Coverage as follows:
    a. 2025-C: Benefits for Fertility Preservation Services Pursuant to Chapter 140 of the Acts of 2024. Carriers are also expected to submit a signed certification to indicate continued compliance with utilization management procedures for the review of fertility preservation services.

b. 2025-D: Managed Care Procedures to Review the Prior Authorization of a Transfer from an Inpatient Facility to Post-Acute Care Pursuant to Chapter 197 of the Acts of 2024. Carriers are also expected to submit a signed certification to indicate continued compliance with utilization management procedures for transfers to post-acute care from an inpatient hospital stay.
c. 2025-E: Prescription Benefits for Chronic Conditions Pursuant to Sections 32-36 of Chapter 342 of the Acts of 2024 (Chapter 342). Carriers are also expected to submit the list of the generic drug(s) selected to be provided for chronic conditions the list of the brand-named drugs according to the requirements of Chapter 342. The list should include the various dosages of Insulin for the treatment of Diabetes, as noted in the law. Carriers are expected to submit a signed certification that the Carrier will be in compliance with utilization management procedures for services required under Chapter 388.
d. 2025-F: Coverage for Opioid Antagonists and Substance Use Recovery Coaches Pursuant to Chapter 285 of the Acts of 2024. Carriers are also expected to submit a signed certification to indicate compliance with the July 1, 2025 and January 1, 2026 required dates for necessary utilization management procedures under Chapter 285.
e. 2025-G: Coverage pursuant to Chapter 388 of the Acts of 2024. Carriers are also expected to submit a signed certification that the Carrier will be in compliance with utilization management procedures for services required under Chapter 388.
f. 2025-H: Coverage of GLP-1 Drugs.
g. 2025-I: Postpartum Maternal Health Benefits Pursuant to Chapter 186 of the Acts of 2024. Carriers are also expected to submit a signed certification that the Carrier will continue to remain in compliance with utilization management procedures for the review of postpartum depression screenings, donor human milk and donor human milk-derived products, and postpartum home visits in accordance with M.G.L. c. 176O and 211 CMR 52.00.
h. 2025-J: Addressing Affordability Within CY26 Merged Market Filings.

III. DEADLINES

Issuers shall refer to the Health Connector RFR for Seal of Approval instructions and additional timelines for QHP and QDP activities at https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-25-1175-1175C-1175L-113349.

Below is the timeline related to the Division's review of QHP and QDP filings and all associated activities.

Dates:	Activity:		
	QHP – On Exchange	**Off Exchange**	**QDP**
4/8/2025	Division Issues QHP and QDP Filing Guidance Notice to all Issuers.		
5/15/2025	**On-Exchange Health Products (including embedded dental benefits)** Issuer deadline to submit to the Division: (1) Plan Management Binders with all completed templates and supporting documentation, which are to be submitted to the Division via SERFF. Final revised versions are to be submitted, if necessary, to account for any changes in the final approved rate filings; and (2) On-Exchange product filings are to be submitted to the Division via SERFF.	**Off-Exchange Health Products** Issuer deadline to submit to the Division: (1) Plan Management Binders with all completed templates and supporting documentation; and (2) Off-Exchange-Only Evidences of Coverage and Schedules of Benefit are to be submitted to the Division via SERFF.	
7/1/2025			**Qualified Stand-alone Dental Plans:** Issuer deadline to submit (1) Plan Management Binders with all completed templates and supporting documentation via SERFF.
9/26/2025	QIS Implementation Plan and Progress Report Form due to all SERFF Plan Binders.		
5/15/2025 – 10/3/2025	Division reviews SERFF filings.		
No later than 10/3/2025	Division places submissions on file and certifies plans in SERFF (for approved plans).		

ADDITIONAL INSTRUCTIONS FOR QHP AND QDP FILINGS

Please note that, in addition to the Network Adequacy work described above, all carriers, including carriers offering QDPs, will continue to be required to submit in SERFF Plan Binders evidence of compliance with network adequacy requirements as follows.

a. Plan provider network documents including:
   i. Electronic copies of medical, dental and vision provider directories. **Please note that if a carrier has multiple networks in the merged market, the carrier will need to provide separate provider directories for each separate network**;
   ii. Geo-access maps of each network identified by network name, along with separate geo-access maps that include access standards for each of the following provider types: acute care facilities; inpatient behavioral health facilities; Primary Care Practitioners; and the following five specialists: Gynecology, Orthopedics, Cardiology, Oncology, and Mental Health/Substance Use Disorder. The Geo-access maps shall contain the same data as the electronic copies of all directories. **Please note that if a carrier has multiple networks in the merged market, the carrier will need to provide separate Geo-access maps, along with corresponding network access analysis for each separate network for each of the identified provider categories; and**
   iii. Network Access Analysis. **Carriers are to provide separate network access analysis documents for each of the carrier's networks showing network adequacy compliance with the standards in Appendix A for each of the provider categories identified in item ii above.**
   iv. **Federal Standards:**
   For details on the federal standards, please see Appendix A attached to this Filing Guidance.

If the Issuer does not believe that any part of the above-noted requested documentation is applicable to its filing, please provide a note in SERFF that explains the justification by line item. It is not sufficient to indicate that an item is not applicable.

If carriers have any questions about these filing instructions, they should contact Niels Puetthoff at niels.puetthoff@mass.gov.

DIVISION OF INSURANCE FILING GUIDANCE NOTICE 2025-M

ADDENDUM A – FEDERAL NETWORK ADEQUACY TIME AND DISTANCE STANDARDS

1. INDIVIDUAL PROVIDER SPECIALTY TYPES (MEDICAL)

Individual Provider Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles					
	Large Metro County		Metro County		Micro County	
	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60
Cardiology	20	10	30	20	50	35
Cardiothoracic Surgery	30	15	60	40	100	75
Chiropractor	30	15	45	30	80	60
Dental	30	15	45	30	80	60
Dermatology	20	10	45	30	60	45
Emergency Medicine	20	10	45	30	80	60
Endocrinology	30	15	60	40	100	75
ENT/Otolaryngology	30	15	45	30	80	60
Gastroenterology	20	10	45	30	60	45
General Surgery	20	10	30	20	50	35
Gynecology, OB/GYN	10	5	15	10	30	20

Infectious Diseases	30	15	60	40	100	75
Nephrology	30	15	45	30	80	60
Neurology	20	10	45	30	60	45
Neurosurgery	30	15	60	40	100	75
Occupational Therapy	20	10	45	30	80	60
Oncology - Medical, Surgical	20	10	45	30	60	45
Oncology - Radiation	30	15	60	40	100	75
Ophthalmology	20	10	30	20	50	35
Orthopedic Surgery	20	10	30	20	50	35
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20
Physical Medicine and Rehabilitation	30	15	45	30	80	60
Physical Therapy	20	10	45	30	80	60
Plastic Surgery	30	15	60	40	100	75
Podiatry	20	10	45	30	60	45
Primary Care – Adult	10	5	15	10	30	20
Primary Care – Pediatric	10	5	15	10	30	20
Psychiatry	20	10	45	30	60	45
Pulmonology	20	10	45	30	60	45

Rheumatology	30	15	60	40	100	75
Speech Therapy	20	10	45	30	80	60
Urology	20	10	45	30	60	45
Vascular Surgery	30	15	60	40	100	75

2. FACILITY SPECIALTY TYPES (MEDICAL)

Facility Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles					
	Large Metro County		Metro County		Micro County	
	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20	10	45	30	80	60
Cardiac Catheterization Services	30	15	60	40	160	120
Cardiac Surgery Program	30	15	60	40	160	120
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75

Mammography	20	10	45	30	80	60
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60
Skilled Nursing Facilities	20	10	45	30	80	60
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60
Urgent Care	20	10	45	30	80	60

3. TIME AND DISTANCE STANDARDS FOR STAND-ALONE DENTAL PLANS

Facility Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles					
	Large Metro County		Metro County		Micro County	
	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60