



COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

One Federal Street, Suite 700 • Boston, MA 02110
(617) 521-7794 • (877) 563-4467 • www.mass.gov/doi

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HEALTH COVERAGE
Filing Guidance Notice: 2026-C

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, 2027

FROM: Niels Puetthoff, Director, Bureau of Managed Care

DATE: March 31, 2026

RE: Submission of Policy Form Materials for the Review of Merged Market Health and Dental Benefit Plans Proposed to be Available as of January 2027

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, 2027.

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 base-benchmark plan for 2017 and subsequent years thereafter, 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 2027 and going forward.

All merged small group/individual market health benefit plans offered and/or renewed in 2027 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 the plans 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. CONSIDERATIONS FOR PY 2027

A. Network Adequacy

Carriers are expected to follow the same process as for PY 2026 related to the submission of materials necessary for the review of network adequacy for PY 2027. Health carriers issuing or renewing health plans in the merged market, and dental carriers issuing or renewing QDPs, will be required to adhere to the standards for adequacy of networks as stated in the attached Addendum A. For details of the provider categories and the time and distance standards, also see attached Addendum A. As with PY 2026, Carriers are advised that the Division and Health Connector will be employing CMS' Alternative Time and Distance Standards for PY 2027 in assessing network adequacy. These alternative standards are for a specific set of provider specialty categories and/or counties only. CMS has not yet released this information for PY 2027. For details, see:

<https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Network-Adequacy>.

Carriers are expected to work with the Division's 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 2027 in the merged market. Although the document submission process will be the same as for PY 2026, each carrier will receive separate communication from the Division to confirm the documents carriers are 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, 2026**.

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 2026 versions.
3. Carriers are expected to comply with the requirements of any recent Division Filing Guidance Notices by incorporating any new language and/or material changes within their Evidences of Coverage as follows:
 - a. 2026-B: Rate and Form Filings for Calendar Year 2027.

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/bs0/external/bidDetail.sda?docId=BD-25-1175-1175C-1175L-125926&external=true&parentUrl=close>.

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
3/31/2026	Division Issues QHP and QDP Filing Guidance Notice to all Issuers.		
5/15/2026	On-Exchange Health Products (including embedded dental benefits)	Off-Exchange Health Products	

Dates:	Activity:		
	QHP – On Exchange	Off Exchange	QDP
	<p>Issuer deadline to submit to the Division:</p> <p>(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</p> <p>(2) On-Exchange product filings are to be submitted to the Division via SERFF.</p>	<p>Issuer deadline to submit to the Division:</p> <p>(1) Plan Management Binders with all completed templates and supporting documentation; and</p> <p>(2) Off-Exchange-Only Evidences of Coverage and Schedules of Benefit are to be submitted to the Division via SERFF.</p>	
7/1/2026			Qualified Stand-alone Dental Plans: Issuer deadline to submit (1) Plan Management Binders with all completed templates and supporting documentation via SERFF.
9/25/2026	QIS Implementation Plan and Progress Report Form due to all SERFF Plan Binders.		
5/15/2026 – 10/2/2026	Division reviews SERFF filings.		
No later than 10/2/2026	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 Addendum A for each of the provider categories identified in item ii above.**

iv. **Time and Distance Standards:**

For details on the time and distance standards, please see Addendum 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 2026-C

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