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HEALTH COVERAGE
Filing Guidance Notice: 2026-J

TO: Insurance Carriers Subject to M.G.L. c. 176O
FROM: Kevin Patrick Beagan, Deputy Commissioner, Health Care Access Bureau
DATE: September 17, 2026
RE: Filings to Implement Amendments to 211 CMR 52.07(3) and 211 CMR 52.07(4)(b)

Filing Guidance Notice 2026-J provides additional clarification to insurance carriers (“Carriers”) about materials required to be submitted to the Division of Insurance (“Division”) in order to implement prospective review (i.e., prior authorization) changes identified in the recent amendments to 211 CMR 52.00, and specifically, 211 CMR 52.07(3) and 211 CMR 52.07(4)(b). The recent amendments to 211 CMR 52.00 apply to prospective review processes; Carriers are reminded that they are expected to follow the requirements of M.G.L. c. 176O and 211 CMR 52.02 et seq. with regard to utilization review.¹ The Division also notes that self-insured accounts are not subject to this guidance but encourages Carriers to seek aligned approaches whenever practicable.

Implementation Plans

As noted in Filing Guidance Notice 2026-I, the Division is developing further guidance concerning elements of the amended regulation in furtherance of orderly and consistent implementation. The Division expects each Carrier to submit a detailed plan for the Division’s review and approval within 45 days of the issuance of guidance documents explaining how the Carrier will implement the prospective review changes.

¹ In 211 CMR 52.02, "Utilization Review" is defined as a “[s]et of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures or settings. Such techniques may include, but are not limited to, Ambulatory Review, Prospective Review, Second Opinion, certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review.” When employing utilization review techniques other than prospective review, Carriers are expected to follow all applicable statutory and regulatory requirements. The Division reminds Carriers that nothing in this filing guidance is meant to limit Carriers’ employment of utilization review techniques under M.G.L. c. 176O and 211 CMR 52.00 when investigating or managing waste or fraud in health insurance markets. The Division also notes that step therapy is separately addressed in section 12A of M.G.L. c. 176O, 211 CMR 52.07(10), and Bulletin 2024-03. Therefore, this filing guidance does not address Carriers’ use of step therapy.

The implementation plan is expected to include an explanation of the steps that the Carrier will follow to modify its internal systems, whenever and wherever necessary, to fully operationalize the changes to the prospective review process. The plan should provide details about how the Carrier will explain to providers and insureds how the changes will go into effect. Once approved, the Carrier is to implement the prospective review changes according to the timelines identified in the approved plans.

Prospective Review Requirements on the Carrier's Website

211 CMR 52.07(3)(b) provides that “[u]tilization Review criteria, including a list of Health Services, supplies and pharmaceuticals requiring preauthorization or Prospective Review, shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made readily accessible in a searchable electronic format to subscribers, Health Care Providers and the general public on a Carrier's website...” It is the Division's expectation that insureds will be able to access the searchable list directly on a Carrier's website and will not have to search on a third-party's website (e.g., that of a pharmacy benefit manager, administrator of behavioral health services, etc.) to access this information.

Changes to Prospective Review Criteria

211 CMR 52.07(3)(c) states that “[a]ny new or amended preauthorization or Prospective Review requirement or restriction shall not be implemented unless the Carrier's publicly accessible website has been updated to clearly reflect the new or amended requirement or restriction and the Carrier has notified Providers at least 60 days prior to the effective date of the new or amended requirement or restriction.” This notification requirement applies to changes that materially restrict access to covered services, such as new prospective review requirements, new step therapy requirements, or revised clinical criteria that introduce new utilization management restrictions. Nothing in this guidance shall be construed to require public disclosure of licensed proprietary criteria beyond the requirements of 211 CMR 52.07(3)(b).

The Division expects that such notifications shall be communicated clearly to providers through multiple channels in written and/or electronic formats, including, but not limited to, on the Carrier's website and provider portal and in the Carrier's regular provider newsletter or bulletin, with special notification being made to providers that there is such a change to the prospective review requirements. Upon request, the Division expects that Carriers will provide a list of all such notifications for the Division's review.

Defining “Necessary Information” in relation to Prospective Review

It is noted in 211 CMR 52.07(4)(b) that “[f]or purposes of 52.07, “necessary information” includes the results of any clinical evaluation that may be required.” When making a prospective review determination, the Division expects a Carrier to collect only the information necessary to make the determination. The Division expects that a Carrier will require only the information included in the Division's standard prior authorization request form, when the Commissioner has designated such a form for the applicable health service, supply, or pharmaceutical. For those services for which a standard prior authorization form applies, and the form is complete, Carriers should not routinely require providers to submit medical records. Medical records may be requested only when necessary to verify medical necessity, and any such request should be limited to the relevant portions of the medical record required for that determination.

Until such time as interoperable systems more fully streamline prospective review processes (e.g., application programming interfaces (APIs)), Carriers may encourage the submission of prospective review requests in an electronic or automated fashion so that decisions can be made with greater speed for

the insured's benefit. However, at this time Carriers also must continue to maintain a residual process to accept the submission of prospective review requests via telephonic and facsimile formats. The continued availability of these residual submission methods does not alter turnaround-time requirements that apply specifically to requests submitted electronically.

Filing Requirement

As set forth above, Carriers shall be expected to file their implementation plans pursuant to this Guidance, which must also include certification of compliance with the amended regulatory requirements and the information set forth in Filing Guidance Notices 2026-J, K and L. If you have questions about any of the information in this guidance, please contact Kevin.Beagan@mass.gov or Niels.Puetthoff@mass.gov.