



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

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HEALTH COVERAGE
Filing Guidance Notice: 2026-K

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(4)

Filing Guidance Notice 2026-K 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(4) (“Initial Determination Regarding a Proposed Admission, Procedure or Service”). The recent amendments to 211 CMR 52.00 apply to prospective review; 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 processes.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 those guidance documents explaining how the Carrier will implement the prospective review changes.

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

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.

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 a plan is approved, the Carrier is to implement the prospective review changes according to the timelines identified in the approved plan.

Prospective Review for Treatment in Cases of Serious Jeopardy

211 CMR 52.07(4)(c) states that in cases of prospective review where “additional delay would result in serious jeopardy to the Insured’s health or well-being, and the Provider electronically requests Prospective Review and presents documentation to the Carrier or Utilization Review Organization of the potential serious jeopardy to the Insured’s health or well-being, a Carrier or its Utilization Review Organization shall make and communicate to the requesting Provider an initial determination not more than 24 hours following the receipt of all necessary information by the Carrier or Utilization Review Organization as applicable.”

It is the Division’s expectation that, when considering an expedited timeline for review, serious jeopardy exists when the insured is experiencing acute symptoms that could result in death, serious bodily impairment, or severe dysfunction of bodily organs; or which could jeopardize the insured’s ability to regain maximum function of bodily organs without immediate medical attention. In relation to behavioral health, it is expected that serious jeopardy would exist when the insured presents a substantial risk of physical harm to self, a substantial risk of physical harm to others, or a substantial risk of physical impairment or injury because the insured’s judgment is so affected that the insured is unable to protect themselves in the community and reasonable protection is not otherwise available.

The Division expects a provider’s decision to seek this expedited review in case of serious jeopardy to be based on the clinical consequences of the delay, rather than solely on the insured’s diagnosis or underlying condition. The Division expects a Carrier to include a clear and conspicuous check box or designated area for providers to indicate on electronic prospective review requests that an additional delay would result in serious jeopardy to the insured’s health or well-being and that the provider’s request is based on the clinical consequences of the delay, rather than solely on the insured’s diagnosis or underlying condition. If a Carrier requests additional information from the requesting provider in order to make a prospective review determination, the 24-hour time requirement will be tolled until all reasonably requested necessary information is received by the Carrier. However, both providers and Carriers are encouraged to process information and the resulting decisions with all due speed consistent with the regulations.

Timing Duration of Prospective Review Authorizations

211 CMR 52.07(4)(e) provides that a “Prospective Review authorization for a prescribed Health Service, supply or pharmaceutical shall be valid for at least 90 days or until the end of the benefit year, whichever is earlier.” It is the Division’s expectation that Carriers will not apply any concurrent review until the expiration of a period that is at least 90 days in length, or until the end of the benefit year, if that is a shorter period than 90 days.

Prospective Review Authorizations for Chronic Disease Management

211 CMR 52.07(4)(e) provides, that “[w]here an Insured is stable on an evidence-based treatment plan for Chronic Disease Management, a Prospective Review authorization for that prescribed Health Service, supply or pharmaceutical shall be valid for the Insured’s course of treatment, including for routine dosage adjustments of a pharmaceutical with an existing Prospective Review authorization, as long as the

Insured's condition remains stable." This does not prohibit the Carrier from requiring transitions, when appropriate, to a therapeutically equivalent or clinically appropriate alternative.

Within 211 CMR 52.02, "Chronic Disease Management" is defined as "[c]are and services for the management of chronic conditions, including (a) conditions, defined by the federal Centers for Medicare and Medicaid Services that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer, and coronary artery disease; (b) congenital anomalies and hereditary conditions; and (c) other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both." It is the Division's expectation that Carriers develop systems and evidences of coverage in accordance with 211 CMR 52.07(4)(e) that apply to health services, supplies, and pharmaceuticals for the treatment of the following chronic conditions:

- Chronic alcohol and other drug dependence
- Autoimmune disorders limited to: Polyarteritis nodosa; Polymyalgia rheumatica; Polymyositis; Rheumatoid arthritis; Systemic lupus erythematosus
- Cancer
- Cardiovascular disorders limited to: Cardiac arrhythmias; Coronary artery disease; Peripheral vascular disease; Chronic venous thromboembolic disorder
- Chronic heart failure
- Dementia
- Diabetes Mellitus
- Chronic viral hepatitis
- Chronic liver disease
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis
- Severe hematologic disorders limited to: Aplastic anemia; Hemophilia; Immune thrombocytopenic purpura; Myelodysplastic syndrome; Sickle-cell disease (excluding sickle-cell trait)
- Glaucoma
- HIV/AIDS
- Chronic lung disorders limited to: Asthma; Chronic bronchitis; Emphysema; Pulmonary fibrosis; Pulmonary hypertension
- Chronic obstructive pulmonary disease (COPD)
- Chronic and disabling mental health conditions limited to: Bipolar disorders; Major depressive disorders; Paranoid disorder; Schizophrenia; Schizoaffective disorder²
- Severe persistent mental illness
- Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS); Epilepsy; Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia); Huntington's disease; Multiple sclerosis; Parkinson's disease; Polyneuropathy Spinal stenosis; Stroke-related neurologic deficit
- Stroke

² Refer to Filing Guidance Notice 2026-L which clarifies that Carriers can apply prospective review for Schedule II or Schedule III pharmaceuticals.

For an insured with a chronic condition who remains in active treatment and is stable while receiving prescribed health services, supplies, or pharmaceuticals provided during the duration of the chronic condition, these services, supplies, or pharmaceuticals – including routine dosage adjustments – are to be covered during that individual’s “course of treatment” under an existing prospective review authorization. With regard to this requirement, only when an insured’s condition changes, the insured is no longer in active treatment, or the insured requires a new service, supply, or pharmaceutical may a Carrier request prospective review of the new service, supply, or pharmaceutical. Carriers are reminded that they are to follow all review timeline, notice, and appeal procedures that are outlined in M.G.L. c. 176O and 211 CMR 52.00.

It is the Division’s expectation that an insured is stable on an evidence-based treatment plan for chronic disease management when the insured is meeting the specific treatment goals established for them by their provider. An insured who has not met such treatment goals is not considered to be stable, even if the condition is unchanged, asymptomatic, or does not present a short-term threat to life or function. Specifically in relation to prescribed supplies and pharmaceuticals, the Division expects the insured is stable on an evidence-based treatment plan for chronic disease management when the insured’s clinical condition is well-controlled without acute exacerbation or significant deterioration under an evidence-based treatment plan. The Division also expects that the insured is stable on an evidence-based treatment plan in those cases when the insured transitions to a therapeutically equivalent alternative pharmaceutical (including instances where the originally prescribed pharmaceutical is removed from the formulary) provided that the substitution is expected to maintain equivalent clinical efficacy and safety for the insured’s chronic disease management.

Continuation of Prospective Review Authorization from a Prior to a New Health Plan

211 CMR 52.07(4)(f) states that, “[w]hen an Insured enrolls in a new Health Benefit Plan, a Prospective Review authorization for a prescribed Health Service, supply or pharmaceutical from the immediate previous health plan will be honored by the new Carrier or Health Benefit Plan for at least 90 days after enrollment; provided that the prescribed Health Service, supply or pharmaceutical is a Covered Benefit under the new Health Benefit Plan.” The Division notes that this section applies when an insured switches Carriers and/or health plans regardless of whether the insured’s immediate previous health plan was a self-insured plan or fully-insured plan.

The Division expects a Carrier to accept a previous prospective review authorization upon receipt of information to reasonably verify that the insured received prospective review authorization from the insured’s immediately preceding health plan for a prescribed health service, supply, or pharmaceutical. The Division expects that a Carrier will honor the prior coverage’s authorization for a health service, supply, or pharmaceutical under the new health benefit plan for at least 90 days following enrollment, provided that the health service, supply, or pharmaceutical is a covered benefit under the Carrier’s plan. Although the prospective review authorization may continue for a period under the new health benefit plan, such coverage will be according to the new plan’s cost-sharing levels, and the Carrier must inform the insured if they are responsible for deductibles, copayments, and coinsurance under the new health benefit plan.

Although 211 CMR 52.07(4)(f) allows a continued benefit of a health service, supply, or pharmaceutical, the Division does not expect that this provision requires continued access to the provider of the health service, supply, or pharmaceutical under the previous health plan, unless a provider is a member of the

new Carrier's network. The new health benefit plan will be expected to identify an in-network provider who is available to deliver the health service, supply, or pharmaceutical to the insured during the continuation period.

Additionally, where the new health benefit plan has a formulary of supplies and pharmaceuticals, the Division does not expect that the authorization extends to the former health plan's supply or pharmaceutical during the continuation period if that brand of supply or pharmaceutical is not part of the new health benefit plan's formulary. The Carrier administering the new health benefit plan must identify the equivalent supply or pharmaceutical to what was approved under the previous health plan and offer the insured the option to receive the equivalent supply or pharmaceutical during the full continuation period.

The Division expects that Carriers may request reasonable documentation regarding the prospective review authorization from the insured's previous health plan, such as approval letters, or provider or member documentation concerning the prospective review authorization. Carriers are expected to do so in a manner that otherwise reduces new administrative burdens.

The Division expects the Carrier to notify the insured about the length of the continuation of the prior health plan's authorization.

Removal of a Specific Health Service, Supply, or Pharmaceutical

211 CMR 52.07(4)(g) provides that "[f]or an Insured who is stable on a prescribed Health Service, supply or pharmaceutical as determined by a Provider and approved for coverage by the Carrier ...and where the Health Service, supply or pharmaceutical is then removed from a Health Benefit Plan's formulary or is subject to new coverage restrictions after the Insured's enrollment period has ended, a Carrier shall cover the approved Health Service, supply or pharmaceutical for 90 days or the rest of the benefit year, whichever is shorter."

The Division expects that a Carrier will notify the insured about the removal of a health service, supply, or pharmaceutical from a health benefit plan's formulary or when the health service, supply, or pharmaceutical is subject to new coverage restrictions – other than normal annual changes to cost-sharing. A Carrier will provide the impacted insureds with written notification with detailed information about the changes, including but not limited to the date when the insured's authorization will change or end. Carriers retain the ability to respond to U.S. Food and Drug Administration safety actions, risk evaluation and mitigation strategy requirements, product withdrawals, significant new clinical evidence, and other patient safety considerations that would necessitate changes in coverage.

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 any questions about any of the information in this guidance, please contact Kevin.Beagan@mass.gov or Niels.Puetthoff@mass.gov.