

211 CMR: DIVISION OF INSURANCE

211 CMR 51.00: PREFERRED PROVIDER HEALTH PLANS AND WORKERS' COMPENSATION PREFERRED PROVIDER ARRANGEMENTS

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51.01: Authority

211 CMR 51.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. c. 152, § 25A, M.G.L. c. 176I, § 8(a) and M.G.L. c. 176O, § 17.

51.02: Definitions

As used in 211 CMR 51.00, the following words mean:

Benefit Level, health benefits provided through a Preferred Provider Health Plan to Covered Persons, as opposed to the payments made to the provider, by the Health Benefit Plan.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, ~~or his or his~~ or her designee.

Covered Person, any policyholder, subscriber, member or dependent on whose behalf the insurer is obligated to pay for and/or provide Health Care Services, including those provided under a workers' compensation Preferred Provider Arrangement under the provisions of M.G.L. c. 152.

Covered Services, Health Care Services that an insurer is obligated to pay for or provide under either a Health Benefit Plan or a workers' compensation insurance policy.

Emergency Care, services provided in or by a hospital emergency facility to a Covered Person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the Covered Person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Covered Person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract, or agreement issued to a Covered Person, including any amendments, riders, or supplementary inserts, stating the health services and benefits to which the Covered Person is entitled under a Preferred Provider Health Plan.

Finding of Neglect, a determination by the Commissioner that an Organization offering a Preferred Provider Health Plan has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

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Health Benefit Plan, the health insurance policy, subscriber agreement, plan, certificate, agreement, or contract between the Covered Person or Health Care Purchaser and an Organization, which defines the Covered Services, and Benefit Levels available.

Health Care Provider, a provider of Health Care Services licensed or registered pursuant to M.G.L. c. 111 or c. 112.

Health Care Purchaser, a person, partnership, association, or corporation that provides health care coverage to its employees or members and their dependents by reimbursing the Covered Persons directly for covered Health Care Services or by contracting with an Organization to provide, arrange for the provision of, reimburse and/or pay for covered Health Care Services.

Health Care Services, services rendered or products sold by a Health Care Provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Insured Health Benefit Plan, a Health Benefit Plan in which the Organization assumes financial risk arising out of the contractual liability to pay for or reimburse Covered Persons for Covered Services. The term does not include a Health Benefit Plan in which an Organization functions solely as a third-party administrator.

Organization, an entity authorized by the Commissioner to bear risk, including, but not limited to companies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L. c. 175, fraternal benefit societies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L. c. 176, non-profit hospital service corporations organized under M.G.L. c. 176A, medical service corporations organized under M.G.L. c. 176B, dental service corporations organized under M.G.L. c. 176E, optometric service corporations organized under M.G.L. c. 176F, or health maintenance organizations licensed pursuant to M.G.L. c. 176G. For the purpose of Workers' Compensation Preferred Provider Arrangements only, "Organization" shall also include an authorized insurer, self-insurer, or self-insurance group as defined in M.G.L. c. 152 §§ 1, 25A and 25E, and any other corporate entity engaged in the delivery or administration of the delivery of health services that has requested approval of a Workers' Compensation Preferred Provider Arrangement on behalf of such insurer, self-insurer or self-insurance group which is acting on behalf of such entity.

Preferred Provider, a Health Care Provider, group of Health Care Providers or a network of providers who have contracted with an Organization to provide specified Covered Services in the context of a Preferred Provider Arrangement.

Preferred Provider Arrangement, a contract between or on behalf of an Organization and a Preferred Provider that complies with all the applicable requirements of M.G.L. c. 152, § 30, c. 176I, and 211 CMR 51.00.

Preferred Provider Health Plan, an insured Health Benefit Plan offered by an Organization that provides incentives for Covered Persons to receive Health Care Services from Preferred Providers in the context of a Preferred Provider Arrangement. A Workers' Compensation Preferred Provider Arrangement shall not be considered a Preferred Provider Health Plan under this regulation.

Usual and Customary Charge, the fees identified by a carrier as the usual fees charged by similar Health Care Providers in the same geographic area.

Workers' Compensation Preferred Provider Arrangement, a Preferred Provider Arrangement between an insurer, self-insurer, or self-insurance group, as defined in M.G.L. c. 152, §§ 1, 25A, or 25E, respectively, and a Preferred Provider to provide all or a specified portion of Health Care Services resulting from workers' compensation claims by Covered Persons against such insurer, self-insurer or self-insurance group under the provisions of M.G.L. c. 152, § 30.

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51.03: Applicability

No Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be offered without meeting the filing and other requirements set forth in M.G.L. c. 152 and 176I, and until it is approved by the Commissioner in accordance with the provisions of 211 CMR 51.00.

51.04: Approval of Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements

(1) Application. No Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be approved without first submitting an application in a format specified by the Commissioner that includes at least the following:

- (a) A description of the geographical area in which the Preferred Providers are located, including a map of the distribution of the Preferred Providers;
- (b) A description of the manner in which covered Health Care Services and other benefits may be obtained by persons using the Preferred Providers, including a description of the grievance system available to Covered Persons, including procedures for the registration and resolution of grievances and any requirement within a Preferred Provider Health Plan that Covered Persons select a gatekeeper provider;
- (c) Provider contracts and contracting criteria, including:
 1. A narrative description of the financial arrangements between the Organization and contracting Health Care Providers, identifying any assumption by the providers of financial risk through arrangements such as *per diems*, diagnosis-related groups, capitation or percentage withholding of fees;
 2. A copy of every standard form contract with preferred physicians and other Health Care Providers, including providers joining the Preferred Provider Arrangement via leasing, subcontracting, or other arrangements whereby the Organization does not contract directly with the providers (do not include rates of payment to providers);
 3. A copy of every standard form contract for all Preferred Provider Arrangements including administrative service agreements;
 4. A copy of the terms and conditions that must be met or agreed to by Health Care Providers desiring to enter into the Preferred Provider Arrangement(s) (do not include rates of payments to Health Care Providers); and
 5. A description of the criteria and method used to select Preferred Providers.
- (d) A detailed description of the utilization review program;
- (e) A detailed description of the quality assurance program;
- (f) Preferred Provider directory, which shall include:
 1. A copy of the Preferred Provider directory distributed to Covered Persons; and
 2. A description of the process for distributing the directory to Covered Persons.
- (g) Filing fee for initial applications as determined by the Executive Office for Administration and Finance as set forth in 801 CMR 4.02.
- (h) Evidence of compliance with M.G.L. c. 176O and 211 CMR 52.00.

(2) Application Materials to be Submitted by Preferred Provider Health Plans Only. In addition to the application required by 211 CMR 51.04(1), Preferred Provider Health Plans must submit:

- (a) A narrative description of the Preferred Provider Health Plan to be offered, including a description of whether the plan will be available to small employers eligible under M.G.L. c. 176J;
- (b) Benefits and Services.
 1. A copy of every standard form contract between the Organization and Health Care Purchasers for the Preferred Provider Health Plan;
 2. A copy of every standard form Evidence of Coverage for every Preferred Provider Health Plan;
 3. A description of any provision for Covered Services to be payable at the preferred level until an adequate network has been established for a particular service or provider type;
 4. A description of all mandated benefits and provider types available at the preferred and non-preferred level;
 5. A description of the incentives for Covered Persons to use the services of Preferred Providers;

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6. A description of any provisions that allow Covered Persons to obtain covered Health Care Services from a non-preferred provider at the Benefit Level for the same covered health care service rendered by a Preferred Provider; and

7. A description of any provisions within the Preferred Provider Health Plan for holding Covered Persons financially harmless for payment denials by, or on behalf of, the Organization for improper utilization of covered Health Care Services caused by Preferred Providers.

(c) Financial Resources.

1. A description of the arrangements to be used by the Organization to protect covered members from financial liability in the event of financial impairment or insolvency of any Preferred Provider that assumes financial risk; and

2. Evidence of a surety bond, reinsurance, or other financial resources adequate to guarantee that the Organization's obligations to Covered Persons will be performed.

(d) Rates.

1. A description of the Organization's methodology for establishing premium rates; and

2. A copy of the average rates for community-rated accounts, non-credible accounts, or their equivalent in the rating structure used by the Organization.

(3) Application Materials to be Submitted by Workers' Compensation Preferred Provider Arrangements Only. In addition to the application required by 211 CMR 51.04(1), Workers' Compensation Preferred Provider Arrangements must submit:

(a) a list of each type of Health Care Provider and medical specialty involved in the proposed Preferred Provider Arrangement and the number of individuals representing each such type of practice and specialty;

(b) a list of each Organization with which the Health Care Provider has previously entered into a Preferred Provider Arrangement, and of each Organization with which the applicant has a pending application for a Preferred Provider Arrangement;

(c) copy of the letter from the Department of Industrial Accidents approving the applicant's ~~arrangement's~~ utilization review and quality assessment program;

(d) a written agreement to abide by, and a description of the procedure to incorporate, any treatment guidelines or protocols promulgated by the Department of Industrial Accidents pursuant to M.G.L. c. 152, §§ 13 and 30;

(e) a procedure to guarantee cooperation by Preferred Providers with the utilization review and quality assurance program which allow for the removal of noncomplying providers from the arrangement;

(f) a procedure for referring Covered Persons to Health Care Services outside the Preferred Provider Plan when indicated by diagnosis, excessive travel time, and presence of any pre-existing medical condition which would make treatment substantially more difficult;

(g) a position statement indicating how the applicant intends to facilitate the return to work of injured employees in a rapid, cost-effective and safe manner;

(h) a copy from the Organization, if a self-insurer or self-insurance group, of the Organization's current authorization to act as a self-insurer or self-insurance group; and

(i) a copy of the information distributed annually to employees which shall include clear reference to the following:

1. that an employee is required to obtain treatment within the Preferred Provider Health Plan for the first scheduled appointment or incur the responsibility to pay for such appointment, provided that such person may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement for the initial scheduled appointment without incurring any financial obligation when such appointment is with a licensed or registered Health Care Provider of a type or specialty not represented within the Preferred Provider Arrangement;

2. that an employee may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement after the initial scheduled appointment without incurring any obligation to pay for such subsequent visit(s) according to the provisions of M.G.L. c. 152, § 30;

3. that no copayments or deductibles may be charged employees with compensable injuries who utilize the Preferred Provider Arrangement or any other Health Care Provider under the provisions of M.G.L. c. 152, §§ 13 and 30;

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4. that each Covered Person has the right to file complaints regarding the provision of Health Care Services with the Health Care Services Board within the Division of Industrial Accidents;

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5. the names of all current Preferred Providers within the geographic region of such Covered Person or of all current Preferred Providers arranged geographically, to be distributed to Covered Persons upon initial approval of the Preferred Provider Arrangement; which shall also be posted in a convenient and prominent place in workplaces where covered workers are employed, and be re-distributed to Covered Persons after any alleged workplace injury or upon request; and

6. a clear description of all other rights of Covered Persons and the obligations of applicants as well as information regarding any restrictions or requirements imposed upon Covered Persons by the Preferred Provider Arrangement's utilization review or quality assurance programs.

(4) Review of Application. Upon receipt of a complete application, the Commissioner will review the submitted material to determine whether applicable requirements set forth in M.G.L. c. 152, ~~&~~ and c. 176I and 211 CMR 51.00 have been met, including the following:

- (a) Corporate and organizational structure capable of supporting the benefits offered;
- (b) Contractual agreements that adequately protect the interests of members;
- (c) Utilization systems ensuring the appropriate and efficient use of ~~health~~ Health Care Services;
- (d) Quality assurance system monitoring the quality of care provided to members;
- (e) Clear and logical plan for marketing of a Preferred Provider Health Plan;
- (f) Adequate Preferred Provider networks to guarantee that all services contracted for will be accessible to members on a preferred basis and in all cases without delays detrimental to the health of Covered Persons;
- (g) Operations capable of administering the Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement and to maintain financial and utilization data for the Preferred Provider Health Plan or Preferred Provider Arrangement in a form separate or separable from other activities of the Organization;
- (h) Sufficient financial reserves to support introduction of a Preferred Provider Health Plan; and
- (i) Submission of all documentation and other materials required by 211 CMR 51.00.

(5) Approval of Application. Each Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement, approved under M.G.L. c. 176I and 211 CMR 51.00, may continue to be marketed unless such approval is subsequently revoked by the Commissioner. Following approval of any Workers' Compensation Preferred Provider Arrangement, a copy of the approved application must then be forwarded to the Office of Health Policy at the Department of Industrial Accidents, ~~600 Washington Street, Boston, MA 02111~~.

(6) Denial of Application. If an application is denied or a Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement is disapproved, the Commissioner shall notify the Organization in writing, stating the reason(s) for the denial. The Organization shall have the right to a hearing within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 30 days after the conclusion of the hearing, the Commissioner shall either grant approval or shall notify the applicant in writing of the denial, stating the reason(s) for the denial. The Organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14.

(7) Licensure. If it is determined during the review of any material submitted that any entity is bearing insurance risk, engaging or proposing to engage in the business of insurance as defined in M.G.L. c. 175; or the business of a nonprofit hospital service corporation as defined in M.G.L. c. 176A; or the business of a medical service corporation as defined in M.G.L. c. 176B; or the business of a dental service corporation as defined in M.G.L. c. 176E; or the business of an optometric service corporation as defined in M.G.L. c. 176F; or the business of a health maintenance organization as defined in M.G.L. c. 176G without proper licensure, the Commissioner will so inform the filer and require ~~the~~ relevant entity to seek licensure under the appropriate statute. ~~The~~ Commissioner may require the filer to submit any information necessary to make this determination.

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51.05: Evidence of Coverage for Insured Preferred Provider Health Plan Coverage Only

The Evidence of Coverage, including all amendments and material changes, must be submitted to the Commissioner for approval.

(1) The Evidence of Coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00, and 211 CMR 52.00.

(2) The Evidence of Coverage must also include the following in clear and understandable language:

(a) a complete description of the benefit differential between services offered by ~~p~~Preferred Providers and non-preferred providers;

(b) Provisions that if a Covered Person receives Emergency Care and cannot reasonably reach a Preferred Provider, payment for such care will be made at the same level and in the same manner as if the Covered Person had been treated by a Preferred Provider;

(c) Benefit levels for covered Health Care Services rendered by non-preferred providers must be at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred Providers.

1. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers.

2. The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.

(d) A description of all benefits required to be provided by law in accordance with all of the provisions of the Organization's enabling or licensing statutes.

51.06: Reporting

(1) Material Changes. Each Organization with a Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to an Evidence of Coverage and significant changes to the lists of Preferred Providers.

(2) Annual Reports. The Division of Insurance will collect annual report information for each Organization with a Preferred Provider Health Plan or a Workers' Compensation Preferred Provider Arrangement shall on April 30th of each year file with the Commissioner a report covering the its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner:

(a) A summary of the number of Covered Persons;

(b) A summary of the utilization experience of Covered Persons; and

(c) A list of preferred providers.

~~current provider directory that lists Preferred Providers by specialty and geographic area.~~

(3) Additional Reports. The Commissioner may require an Organization to submit additional reports other than those specifically required by M.G.L. c. 176I.

(4) Penalties.

(a) If, after due hearing, a person or Organization is found to have violated any provision of M.G.L. c. 176I or 211 CMR 51.00, or any rule or order thereunder, the Commissioner may require the person or Organization to cease and desist from such violations and the Commissioner may require the person or Organization to forfeit an amount not to exceed \$10,000 for any single violation.

(b) If the Commissioner issues a Finding of Neglect on the part of an Organization offering a Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement, the Commissioner shall notify the Organization in writing that the Organization has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the Organization \$5000 for each day the neglect

continues.

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(c) Following notice and hearing, the Commissioner shall suspend the Organization's authority to offer a Preferred Provider Health Plan or use a Workers' Compensation Preferred Provider Arrangement until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the Finding of Neglect can be removed.

51.07: Severability

If any provision of 211 CMR 51.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 51.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 51.00: M.G.L. c. 176I, § 8(a) and M.G.L. c. 176O, § 17.

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