RESET FROM

MANAGED CARE CHECKLIST:
REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS
LICENSED UNDER M.G.L. c. 176G

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:

Pursuant to Bulletin No. 2001-05 and 2008-19, include a completed checklist when submitting (1) an application for accreditation; (2) a material change to accreditation; (3) an application for an insured preferred provider plan.

When completing a checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.

- ***For items requiring company confirmation, please place a checkmark (√) next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable, please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.***

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____

Product Name & Form #: _____

Date Submitted: _____

Carrier Certification:
I _____ a duly authorized representative of _____ certify that it is my good faith belief based on the review of this checklist and submitted evidence of coverage and additional materials that the evidence of coverage and additional submitted materials comply with applicable Massachusetts law.

ADDITIONAL CHECKLISTS

Review the following checklists below; complete and forward those that apply to your submission.

- CHECKLIST FOR THE INITIAL APPROVAL OF AN INSURED PREFERRED PROVIDER PLAN ***(Form# Application For Approval - Insured Preferred Provider Plan ver091217.pdf)***;
- MANAGED CARE CHECKLIST: FILING CONTENT FOR RENEWAL APPLICATION OF ACCREDITATION UNDER M.G.L. c. 176O (***Form# MC_RenewalAccred_090117.pdf)***; and
- MANAGED CARE CHECKLIST: REQUIREMENTS FOR PROVIDER CONTRACTS ***(Form# Managed Care Provider Contracts (Rev. 083017) FINAL.pdf)***.

SPECIFIC TO MATERIAL CHANGE SUBMISSIONS

(Pursuant to M.G.L. c. 176I & c. 176O and regulations 211 CMR 51.00 & 211 CMR 52.00)

According to 211 CMR 52.02 the term "material change" is defined as "[a] modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

an Insured;
a Carrier, including a Dental or Vision Carrier; and/or
a Health, Dental, or Vision Care Provider."

According to 211 CMR 51.06(1), "[e]ach Organization with a Preferred Provider Health Plan…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."

IF the submission is a material change, review all pages of this checklist;

- **complete only those sections of the checklist(s) specific to the submission; and**
- **include red-line version(s) of the previously filed document(s).**

HIGH DEDUCTIBLE PLANS THAT QUALIFY FOR USE WITH AN HSA

As stated in M.G.L.176G §16A, "[t]he commissioner shall not disapprove a health maintenance contract: (i) if it complies with the requirements of 42 U.S.C. Sec. 18022(e); or (ii) on the basis that it includes a deductible that is consistent with the requirements for a high deductible plan as defined in section 223 of the Internal Revenue Code and implementing regulations or guidelines; provided, however, that the maximum deductible shall not be greater than the maximum annual contribution to a health savings account permitted under said section 223 of the Internal Revenue Code; and, provided further, that a deductible equal to the maximum annual contribution to a health savings account shall only be approved for products which include a health savings account permitted under said section 223 of the Internal Revenue Code.

Include a statement to explain the maximum individual and Family deductible options that the carrier intends to offer.

If offering an HSA compatible plan please complete the following:

Deductible & out-of-Pocket Limits for High-Deductible Health Plans for use with an HSA		
Plan Features	**In-network – Ind/Fam.**	**Out-of-Network – Ind/Fam as applicable**
Maximum Deductibles In-Network/Out-of-network as applicable		
Maximum out-of-pocket Maximum In-Network/Out-of-network as applicable		
Family Deductible Feature		
1) Embedded Deductible per Member; or		
2) Aggregate Deductible		

RATE FILING REQUIREMENTS - ("Filing Guidance Notice 2012-E" issued on July 11, 2012)

Applies to all health benefit plans [**does not apply to stand alone dental or vision plans**] for which rates are filed on a periodic basis, including merged market (small group and individual) plans, HMO plans and Blue Cross Blue Shield of Massachusetts plans.

Please advise whether submission will have an impact on rates.

YES ☐ **NO** ☐

IF YES, forward the applicable rates with your quarterly rate filing via SERFF. Rates will not be approved until the forms review is complete.

READABILITY OF POLICY FORM; DEFINITION; APPROVAL; ACTIONS BASED ON LANGUAGE - [M.G.L. CHAPTER 175 §2B]

Applies to policy forms, all certificates and subscription agreements or contracts of insurance issued pursuant to M.G.L. c. 176, c. 176A, c. 176B, c. 176G. Policyholder shall include, in addition to all insurance policyholders, all subscribers and holders of certificates issued pursuant to M.G.L. c. 176, c. 176A, c. 176B, c. 176G - ***M.G.L. c. 175 §2B. 2.***

Every policy form filed with the commissioner under this section shall be accompanied by a certificate stating the Flesch scale readability score achieved by such form(s).
[Statutory citation should be stated within the certification]

The term "text" as used in this section shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, captions and subcaptions, and schedule pages and tables.
No policy form of insurance shall be delivered or issued for delivery to more than fifty policyholders in the commonwealth until a copy of the policy form has been on file for thirty days with the commissioner, unless before the expiration of said thirty days the commissioner shall have approved the form of the policy in writing as complying with this section; nor shall any such policy be delivered or issued for delivery if the commissioner notifies the company in writing within said thirty days that in his opinion the form of said policy does not comply with the provisions of this section, specifying the reasons for his opinion, provided that such action of the commissioner shall be subject to review by the supreme judicial court, but during any such review the form shall not be delivered or issued for delivery in the commonwealth; nor shall any such policy form be so delivered or issued for delivery unless:

The text achieves a minimum Flesch scale readability score of fifty; ***M.G.L. c. 175 §2B. 1.(a)***

It is printed, except for tables, in not less than ten point type, one point leaded;
M.G.L. c. 175 §2B. 1.(b)

The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders; ***M.G.L. c. 175 §2B. 1.(c)***

It contains a table of contents or an alphabetical subject index; ***M.G.L. c. 175 §2B. 1.(d)***

The width of margins and ink to paper contrast do not unreasonably interfere with the readability of the form; and ***M.G.L. c. 175 §2B. 1.(e)***

The organization of the content of the policy and the summary of the policy is conducive to understandability of the form. ***M.G.L. c. 175 §2B. 1.(f)***

The certification identifies each form by form identifier and identifies the actual Flesch score for each form - **a statement to the effect that the score exceeds 50 is not permitted**.

MINIMUM CREDITABLE COVERAGE NOTICES

(BULLETIN 2008-02 & BULLETIN 2010-07)

As of January 1, 2009, the Massachusetts Health Care Reform Law requires each Massachusetts resident, eighteen (18) years of age and older, to have health coverage that meets the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector.

In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate all commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (collectively "carriers") that offer or renew an individual or group insured health plan in Massachusetts, as defined in M.G.L. c. 176N, with coverage effective on or after February 1, 2008...are to disclose to insureds and potential insureds a plan's MCC status and whether the plan satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law.

The insured health plan's MCC status will be based on compliance with applicable standards in effect on and after January 1, 2009 as set forth by the Connector either by regulation or administrative bulletin.

In the case of an employer-sponsored group insured health plan, said disclosure requirement also applies to marketing materials that describe the insured health plan benefits that are used during the employer's open enrollment period.

Please confirm that the carrier complies with this requirement.

_____

The filed product **meets MCC standards**;
The filed product **does not meet MCC standards**;
The filed product **is not considered a "health plan", as defined in M.G.L. c. 176N**.

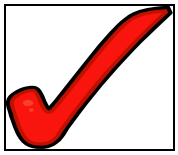
Please confirm that the carrier complies with this requirement.

_____

_____

IF THE INSURED HEALTH PLAN MEETS MCC STANDARDS:

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format:



This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective ***[January 1, 20XX - (carriers are to substitute applicable date)]*** as part of the Massachusetts Health Care Reform Law. If you purchased this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE ***[JANUARY 1, 20XX (carriers are to substitute applicable date)]***. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

IF THE INSURED HEALTH PLAN DOES NOT MEET MCC STANDARDS

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format: :

This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan, alone, **does not meet Minimum Creditable Coverage standards** that are effective ***[January 1, 20XX - (carriers are to substitute applicable date)]*** as part of the Massachusetts Health Care Reform Law because *(carriers are to substitute applicable minimum creditable coverage standards as set by the Connector)*:

- The in-network deductible is more than $2,050 for an individual and/or $4,100 for a family.
- A broad range of medical benefits, as defined by the Connector, are not covered.
- Prescription drugs are not covered.
- The deductible for prescription drug coverage is more than $250 for an individual and/or $500 for a family.
- The health plan includes deductibles or coinsurance for in-network core services, but does not include an out-of-pocket maximum for in-network covered services.
- The out-of-pocket maximum for in-network covered services exceeds [$$$$].
  [Note: Insert the appropriate dollar amount in effect for taxable year.]
- The sum of the out-of-pocket maximums [*e.g.* separate medical and RX deductibles] for in-network covered services exceeds [$$$$]. [Note: Insert the appropriate dollar amount in effect for taxable year.]
- The out-of-pocket maximum does not include [note: select appropriate service(s): deductibles, co-insurance, co-payments, or similar charges],
- The health plan imposes an overall annual maximum benefit limitation for the plan that applies to all covered services collectively;

- The health plan imposes an overall annual maximum dollar benefit limitation.
- The health plan imposes utilization a cap on covered core services, The health plan imposes impose an overall annual maximum dollar benefit limitation on prescription drugs;
- The health plan limits benefits to an Indemnity Schedule of Benefits for the coverage of core services.
- The health plan applies covered preventive health services to the deductible.

If you purchased this health plan only, **you will not satisfy** the statutory requirement that you have health insurance meeting these standards.

If this health plan is offered to you through your place of employment, contact your employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your employer or other plan sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.

If this health plan is not offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE ***[JANUARY 1, 20XX (carriers are to substitute applicable date)]***. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi

MANAGED CARE

DEFINITIONS MANAGED CARE [M.G.L. c. 176O §1 and 211 CMR 52.03 (if used)]:

Insert page number(s), and/or section(s)

Pg#_____ Accreditation. A written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Pg#_____ Actively Practices. A Health Care Professional who regularly treats patients in a clinical setting.

Pg#_____ Administrative Disenrollment. A change in the status of an Insured whereby the Insured remains with the same Carrier but his or her membership may appear under a different identification number. Examples of an Administrative Disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that maybe recorded by the Carrier as both a disenrollment and an enrollment.

Pg#_____ Adverse Determination. A determination, based upon a review of information provided, by a Carrier or its designated Utilization Review Organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other Health Care Services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational.

Pg#_____ Alternative Payment Contract. Any contract between a Carrier and a Provider or Provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for-service payments that are settled or reconciled with a bundled or global payment.

Pg#_____ Ambulatory Review. Utilization Review of Health Care Services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency Facility, as well as other locations such as laboratories, radiology facilities, Provider offices and patient homes.

Pg#_____ Behavioral Health Manager. a company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth, that has entered into a contractual arrangement with a Carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled members of the Carrier.

Pg#_____ Bureau of Managed Care or Bureau. The bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Pg#_____ Capitation. A set payment per patient per unit of time made by a Carrier to a licensed Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of Health Care Professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Pg#_____ Carrier. An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer

purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "Carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1.

Pg#_____ Case Management. A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Pg#_____ Clean and Complete Credentialing Application. A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier.

Pg#_____ Clinical Peer Reviewer. A physician or other Health Care Professional, other than the physician or other Health Care Professional who made the initial decision, who holds a nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician Health Care Professionals, the recognized professional board for their specialty, who Actively Practices in the Same or Similar Specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Pg#_____ Clinical Review Criteria. The written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a Carrier to determine the Medical Necessity and appropriateness of Health Care Services.

Pg#_____ Commissioner. The Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Pg#_____ Complaint.

(a) any Inquiry made by or on behalf of an Insured to a Carrier or Utilization Review Organization that is not explained or resolved to the Insured's satisfaction within three business Days of the Inquiry;

(b) any matter concerning an Adverse Determination; or

(c) in the case of a Carrier or Utilization Review Organization that does not have an internal Inquiry process, a Complaint means any Inquiry.

Pg#_____ Concurrent Review. Utilization Review conducted during an Insured's inpatient hospital stay or course of treatment.

Pg#_____ Cost Sharing or Cost-sharing. Includes deductibles, coinsurance, copayments, or similar charges required of an Insured, but does not include premiums, balance-billing amounts for out-of-network Providers, or spending for non-covered Benefits.

Pg#_____ Covered Benefits or Benefits. Health Care Services to which an Insured is entitled under the terms of the Health Benefit Plan.

Pg#_____ Days. Calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Pg#_____ Dental Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Dental Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Dental Care Services.

Pg#_____ Dental Care Professional. A dentist or other dental care practitioner licensed, accredited or certified to perform specified Dental Services consistent with the law.

Pg#_____ Dental Care Provider. A Dental Care Professional or Facility licensed to provide Dental Care Services.

Pg#_____ Dental Care Services or Dental Services. Services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

Pg#_____ Dental Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Dental Care Services and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a dental service corporation organized under M.G.L. c. 176E, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees or one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Dental Care Services.

Pg#_____ Discharge Planning. The formal process for determining, prior to discharge from a Facility, the coordination and management of the care that an Insured receives following discharge from a Facility.

Pg#_____ Division. The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Pg#_____ Emergency Medical Condition. A medical condition, whether physical, behavioral, related to substance use disorder, 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 an Insured or another 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 § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Pg#_____ Evidence of Coverage. Any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the Insured is entitled. For workers' compensation preferred provider arrangements, the Evidence of Coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.

Pg#_____ Facility. A licensed institution providing Health Care Services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Pg#_____ Finding of Neglect. A written determination by the Commissioner that a Carrier 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.

Pg#_____ Grievance. Any oral or written Complaint submitted to the Carrier that has been initiated by an Insured, or on behalf of an Insured with the consent of the Insured, concerning any aspect or action of the Carrier relative to the Insured, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Pg#_____ Health Benefit Plan. A policy, contract, certificate or agreement of insurance entered into,

offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. Unless otherwise noted, Health Benefit Plan shall not include any policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1.

Pg#_____ Health Care Professional. A physician or other health care practitioner licensed, accredited or certified to perform specified Health Services consistent with the law.

Pg#_____ Health Care Provider or Provider. A Health Care Professional or Facility.

Pg#_____ Health Care Services or Health Services. Services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

Pg#_____ HMO. A health maintenance organization licensed pursuant to M.G.L. c. 176G.

Pg#_____ Incentive Plan. Any compensation arrangement between a Carrier and Health Care Professional or Licensed Health Care Provider Group or organization that employs or utilizes services of one or more licensed Health Care Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to Insureds of the organization. Incentive Plan shall not mean contracts that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Health Care Professionals or Providers, or Health Care Professional groups or Provider groups which are made with respect to groups of Insureds if such contracts, which impose risk on such Health Care Professionals or Providers or Health Care Professional groups or Provider groups for the cost of medical care, services and equipment provided or authorized by another Health Care Professional or Provider or by another Health Care Professional group or Provider group, comply with 211 CMR 52.00.

Pg#_____ Inquiry. Any communication by or on behalf of an Insured to the Carrier or Utilization Review Organization that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Carrier.

Pg#_____ Insured. An enrollee, covered person, Insured, member, policy holder or subscriber of a Carrier, including a Dental or Vision Carrier, including an individual whose eligibility as an Insured of a Carrier is in dispute or under review, or any other individual whose care may be subject to review by a Utilization Review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Pg#_____ Internet Website. Includes, but shall not be limited to, an internet website, an intranet website, a web portal, or electronic mail.

Pg#_____ JCAHO. The Joint Commission on Accreditation of Healthcare Organizations.

Pg#_____ Licensed Health Care Provider Group. A partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a Licensed Health Care Provider Group only if it is composed of individual Health Care Professionals and has no subcontracts with Licensed Health Care Provider Groups.

Pg#_____ Limited Health Services. Pharmaceutical services, and such other services as may be determined by the Commissioner to be Limited Health Services. Limited Health Services shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the Limited Health Services set forth in the preceding sentence.

Pg#_____ Limited Network Plan. A limited network plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

Pg#_____ Managed Care Organization or MCO. A Carrier subject to M.G.L. c. 176O.

Pg#_____ Material Change. A modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

an Insured;
a Carrier, including a Dental or Vision Carrier; and/or
a health, Dental, or Vision Care Provider.

Pg#_____ Medical Necessity or Medically Necessary. Health Care Services that are consistent with generally accepted principles of professional medical practice as determined by whether:

a) the service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harms to the individual;
b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
c) for services and interventions not in widespread use, is based on scientific evidence.

Pg#_____ National Accreditation Organization. JCAHO, NCQA, URAC or any other national accreditation entity approved by the Division that accredits Carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

Pg#_____ NCQA. The National Committee for Quality Assurance.

Pg#_____ NCQA Standards. The Standards and Guidelines for the Accreditation of Health Plans published annually by the NCQA.

Pg#_____ Network or Provider Network. A group of health, Dental or Vision Care Providers who contract with a Carrier, including a Dental or Vision Carrier, or affiliate to provide health, Dental or Vision Care Services to Insureds covered by any or all of the Carrier's, including a Dental or Vision Carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those Participating Providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

Pg#_____ Nongatekeeper Preferred Provider Plan. An insured preferred provider plan approved for offer under M.G.L. c. 176I which offers preferred Benefits when a covered person receives care from preferred Network Providers but does not require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any Network Provider as a condition of receiving Benefits at the preferred benefit level.

Pg#_____ Nurse Practitioner. A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, § 80B.

Pg#_____ Office of Patient Protection. The office within the Health Policy Commission established by M.G.L. c. 6D, § 16, responsible for the administration and enforcement of M.G.L. c. 176O, §§ 13, 14, 15 and 16.

Pg#_____ Participating Provider. A Provider who, under a contract with the Carrier, including a Dental or Vision Carrier, or with its contractor or subcontractor, has agreed to provide health, Dental or Vision Care Services to Insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Carrier, including a Dental or Vision Carrier.

Pg#_____ Physician Assistant. A person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with M.G.L. c. 112, §§ 9C through 9H and who has passed the Physician Assistant National Certifying Exam or its equivalent.

Pg#_____ Preventive Health Services. Any periodic, routine, screening or other services designed for the prevention and early detection of illness that a Carrier is required to provide pursuant to Massachusetts or federal law.

Pg#_____ Primary Care Provider. A Health Care Professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; initiates referrals for specialist care; and maintains continuity of care within the scope of his or her practice.

Pg#_____ Prospective Review. Utilization Review conducted prior to an admission or a course of treatment. Prospective Review shall include any pre-authorization and pre-certification requirements of a Carrier or Utilization Review Organization.

Pg#_____ Regional Network Plan. A regional network plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks.*

Pg#_____ Religious Non-medical Provider. A Provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Pg#_____ Retrospective Review. Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. Retrospective Review shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Pg#_____ Same or Similar Specialty. The Health Care Professional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the Grievance. Such experience shall extend to the treatment of children in a Grievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is Medically Necessary.

Pg#_____ Second Opinion. An opportunity or requirement to obtain a clinical evaluation by a Health Care Professional other than the Health Care Professional who made the original recommendation for a proposed Health Service, to assess the clinical necessity and appropriateness of the initial proposed Health Service.

Pg#_____ Service Area. The geographical area as approved by the Commissioner within which the Carrier, including a Dental or Vision Carrier, has developed a Network of Providers to afford adequate access to members for covered Health, Dental or Vision Services.

Pg#_____ Terminally Ill or Terminal Illness. An illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

Pg#_____ Tiered Network Plan. A tiered network plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

Pg#_____ URAC. The American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Pg#_____ Utilization Review. Set 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.

Pg#_____ Utilization Review Organization. An entity that conducts Utilization Review under contract with or on behalf of a Carrier, but does not include a Carrier performing Utilization Review for its own Health Benefit Plans. A Behavioral Health Manager is considered a Utilization Review Organization.

Pg#_____ Vision Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Vision Care Services.

Pg#_____ Vision Care Professional. An ophthalmologist, optometrist or other practitioner licensed, accredited or certified to perform specified Vision Services consistent with the law.

Pg#_____ Vision Care Provider. A Vision Care Professional; or a Facility licensed to perform and provide Vision Care Services.

Pg#_____ Vision Care Services or Vision Services. Services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

Pg#_____ Vision Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Vision Care Services and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Vision Care Services.

STANDARDS FOR UTILIZATION REVIEW - 211 CMR 52.06

Carriers shall meet the requirements identified in 211 CMR 52.07(2) through (10). In cases where the standards in 211 CMR 52.07(2) through (10) differ from those in the NCQA Standards, the standards in 211 CMR 52.07(2) through (10) shall apply. **According to 211 CMR 52.13(3)(o), evidences of coverage shall contain a summary description of utilization review procedures as follows:**

211 CMR 52.06(2): Written Plan.

Pg#_____ Utilization Review conducted by a Carrier or a Utilization Review Organization shall be conducted pursuant to a written plan under the supervision of a physician and staffed by appropriately trained and qualified personnel and shall include a documented process to:

a) review and evaluate its effectiveness;
b) ensure the consistent application of Utilization Review criteria; and
c) ensure the timeliness of Utilization Review determinations.

211 CMR 52.07(3): Criteria.

A Carrier or Utilization Review Organization shall adopt Utilization Review criteria and conduct all Utilization Review activities pursuant to said criteria.

Pg#_____ a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of Participating Providers, consistent with the development of Medical Necessity criteria consistent with 958 CMR 3.101: *Carrier's Medical Necessity Guidelines*.

Pg#_____ b) Utilization Review criteria shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made easily accessible to subscribers, Health Care Providers and the general public on a Carrier's website; or, in the alternative, on the Carrier's Utilization Review Organization's website so long as the Carrier provides a link on its website to the Utilization Review Organization's website; provided, however, that a Carrier shall not be required to disclose licensed, proprietary criteria purchased by a Carrier or Utilization Review Organization on its website, but must disclose such criteria to a Provider or subscriber upon request.

Pg#_____ c) Any new or amended preauthorization requirement or restriction shall not be implemented unless the Carrier's and/or Utilization Review Organization's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Pg#_____ d) Adverse Determinations rendered by a program of Utilization Review, or other denials of requests for Health Services, shall be made by a person licensed in the appropriate specialty related to such Health Services and, where applicable, by a Provider in the same licensure category as the ordering Provider.

211 CMR 52.07(4) Initial Determination Regarding a Proposed Admission, Procedure or Service.

Pg#_____ (a) When requiring prior authorization for a Health Care Service or Benefit, a Carrier shall use and accept, or a Carrier shall require and ensure that its Utilization Review Organization use and accept, only the prior authorization forms designated by the Commissioner for the specific types of Health Care Services and Benefits identified in the designated forms.

Pg#_____ (b) If the Carrier fails to use or accept the designated prior authorization form, or fails to respond within two business days after receiving a completed prior authorization request from a Provider, pursuant to the submission of the prior authorization form under 211 CMR 52.07(4)(a), the prior authorization request shall be deemed to have been granted.

Pg#_____ (c) In addition to any other requirements under applicable law, a Carrier shall make, or a Carrier shall require and ensure that its Utilization Review Organization makes, an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information. For purposes of 211 CMR 52.07, "necessary information" shall include the results of any face-to-face clinical evaluation or Second Opinion that may be required.

Pg#_____ (d) In the case of a determination to approve an admission, procedure or service, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the Provider within two working days thereafter.

Pg#_____ (e) In the case of an Adverse Determination, the Carrier or the Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the Provider within one working day thereafter.

Pg#_____ (f) Any new or amended Prospective Review requirement or restriction shall not be effective unless and until the Carrier's or Utilization Review Organization's website has been updated to reflect the new or amended requirement or restriction.

Pg#_____ (g) Subject to 211 CMR 52.07(4)(a) through (f), nothing in 211 CMR 52.07(4) shall:

1. require a treating Health Care Provider to obtain information regarding whether a proposed admission, procedure or service is Medically Necessary on behalf of an Insured;
2. restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not Medically Necessary, based on information provided at the time of claim; or
3. shall restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim.

211 CMR 52.07(5) Concurrent Review.

Pg#_____ A Carrier or the Utilization Review Organization shall make a Concurrent Review determination within one working day of obtaining all necessary information.

a) In the case of a determination to approve an extended stay or additional services, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the Insured and the Provider within one working day thereafter. A written or electronic notification shall include the number of extended Days or the next review date, the new total number of Days or services approved, and the date of admission or initiation of services.

b) In the case of an Adverse Determination, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within 24

hours, and shall send written or electronic notification to the Insured and the Provider within one working Day thereafter.

c) The service shall be continued without liability to the Insured until the Insured has been notified of the determination.

211 CMR 52.07(6) Written Notice. (See also Bulletin 2016-02)

The written notification of an Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

Pg#_____ (a) include information about the claim including, if applicable, the date(s) of service, the Health Care Provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s);

Pg#_____ (b) identify the specific information upon which the Adverse Determination was based shall explain the reason for any denial, including the specific Utilization Review criteria or Benefits provisions used in the determination, and;

Pg#_____ (c) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions;

Pg#_____ (d) explain in a reasonable level of detail the specific reasons such medical evidence fails to meet the relevant medical review criteria;

Pg#_____ (e) reference and include, or provide a website link(s) to the specifically applicable, clinical practice guidelines, medical review criteria, or other clinical basis for the Adverse Determination;

Pg#_____ (f) a description of any additional material or information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary;

Pg#_____ (g) if the carrier specifies alternative treatment options which are Covered Benefits, include identification of providers who are currently accepting new patients;

Pg#_____ (h) prominently explain all appeal rights applicable to the denial, including a clear, concise and complete description of the Carrier's formal internal Grievance process and the procedures for obtaining external review pursuant to 958 CMR 3.000: *Health Insurance Consumer Protection*, and a clear, prominent description of the process for seeking expedited internal review and concurrent expedited internal and external reviews, including applicable timelines, pursuant to 958 CMR 3.000; and a clear and prominent notice of a patient's right to file a grievance with the with the Office of Patient Protection; and information on how to file a grievance with the Office of Patient Protection.

Pg#_____ (i) prominently notify the Insured of the availability of, and contact information for, the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the Massachusetts consumer assistance program; and

Pg#_____ (j) include a statement, prominently displayed in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*.

211 CMR 52.07(7) Reconsideration of an Adverse Determination.

A Carrier or Utilization Review Organization shall give a Provider treating an Insured an opportunity to seek reconsideration of an Adverse Determination from a Clinical Peer Reviewer in any case involving an initial determination or a Concurrent Review determination.

Pg#_____ (a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the Provider rendering the service and the Clinical Peer Reviewer or a clinical peer designated by the Clinical Peer Reviewer if the reviewer

cannot be available within one working day.

Pg#_____ (b) If the Adverse Determination is not reversed by the reconsideration process, the Insured, or the Provider on behalf of the Insured, may pursue the Grievance process established pursuant to 958 CMR 3.000: *Health Insurance Consumer Protection*.

Pg#_____ (c) The reconsideration process allowed pursuant to 211 CMR 52.07(7) shall not be a prerequisite to the internal Grievance process or an expedited appeal required by 958 CMR 3.000: *Health Insurance Consumer Protection*.

211 CMR 52.07(10) Annual Survey

A Carrier or Utilization Review Organization shall conduct an annual survey of Insureds to assess satisfaction with access to primary care services, specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of Insureds with projected measures of their satisfaction.

(b) Carriers that utilize Incentive Plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of Health Care Services of Insureds.

Please confirm the carrier understands their responsibilities noted above.

_____

211 CMR 52.07(11) Religious Non-medical Treatment and Providers.

Nothing in 211 CMR 52.07 shall be construed to require Health Benefit Plans to use medical professionals or criteria to decide insured access to Religious Non-medical Providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by Religious Non-medical Providers, compel an Insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a Religious Non-medical Provider, or require Health Benefit Plans to exclude Religious Non-medical Providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the Provider.

Please confirm the carrier understands their responsibilities noted above.

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DESCRIPTION OF STANDARD HMO SERVICES

[M.G.L. c. 176G §1 and 211 CMR 43.00]

Description of services should be identified within the policy forms – identify the page number for each identified "health service."

Health Services at least reasonably comprehensive inpatient, outpatient, and emergency care services including: preventive services, such as:

Pg ____ immunizations;
Pg ____ periodic health exams for adults;
Pg ____ prenatal maternity care;
Pg ____ well child care including vision and auditory screening;
Pg ____ voluntary family planning;
Pg ____ nutrition counseling, and health education;
Pg ____ pediatric care;
Pg ____ minimum of 100 days in a 12-month period or 365 lifetime days of noncustodial care in a skilled nursing facility; and
Pg ____ which may include, but not be limited to chiropractic services; optometric services; and podiatric services.

REQUIREMENTS OF AN EVIDENCE OF COVERAGE

[M.G.L. c. 176O §6 211 CMR 52.13]:

211 CMR 52.13(1): Evidences of Coverage as to a Carrier.

It shall constitute delivery of an Evidence of Coverage if a carrier chooses to, upon or after enrollment, require the Insured to designate whether the Insured wants to receive an Evidence of Coverage electronically or in writing. If no option is designated, the Evidence of Coverage shall be provided electronically. If the insured designates written notice, a carrier shall issue and deliver to at least one adult Insured in the household an Evidence of Coverage. If the Insured designates electronic notice, a carrier shall refer the insured to a resource where the information described in such Evidence of Coverage can be accessed, including, but not limited to, an Internet Website. In such instance, the Evidence of Coverage must meet the requirements of 211 CMR 52.13(4). An electronic copy of the Evidence of Coverage shall always be delivered to the group representative in the case of a group policy.

Based on the above, please provide a detailed statement describing how the carrier delivers its evidence of coverage to insureds upon or after enrollment as well as to the group representative, as applicable.

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211 CMR 52.13(3): Evidences of Coverage Requirements.

An Evidence of Coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.13(3)(a) through (aa). In addition, for Limited, Regional and Tiered Network Plans, an Evidence of Coverage shall also contain any information as required by 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

Pg#_____ a) The health, Dental or Vision Care Services and any other Benefits to which the Insured is entitled on a nondiscriminatory basis, including Benefits mandated by state or federal law;

Pg#_____ b) The prepaid fee which must be paid by or on behalf of the Insured and an explanation of any grace period for the payment of any Health Benefit Plan premium;

Pg#_____ c) The toll-free telephone number and website established by the Carrier to present Provider cost information and an explanation of the information that a Insured may obtain through such toll-free number and website.

d) The limitations on the scope of:

Pg#_____ 1. Health Care Services and any other Benefits to be provided, including:

Pg#_____ a. an explanation of any Facility fee, allowed amount, coinsurance, copayment, deductible or other amount that the Insured may be responsible to pay to obtain Covered Benefits from Network or Out-of-network Providers; and

Pg#_____ b. an explanation of the information that an Insured may obtain through the toll-free number and website established by the Carrier under 211 CMR 52.14(4).

Pg#_____ 2. Dental or Vision Care Services and any other Benefits to be provided, including an explanation of any deductible or copayment feature.

Pg#_____ e) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the Health, Dental or Vision Benefit Plan;

Pg#_____ f) A description of the locations where, and the manner in which, Health, Dental or

Vision Care Services and other Benefits may be obtained, and, additionally, for Health Care Services:

Pg#_____ 1. the method to locate Provider directory information on a Carrier's website and the method to obtain a paper Provider directory;

Pg#_____ 2. an explanation that whenever a proposed admission, procedure or covered service that is Medically Necessary is not available to an Insured within the Carrier's Network, the Carrier will cover the out-of-Network admission, procedure or service, and the Insured will not be responsible for paying more than the amount which would be required for a similar admission, procedure or service offered within the Carrier's Network; and

Pg#_____ 3. an explanation that whenever a location where Health Care Services are provided is part of a Carrier's Network, the Carrier will cover Medically Necessary covered Benefits delivered at that location, and an explanation that the Insured will not be responsible for paying more than the amount required for Network services delivered at that location even if part of the Medically Necessary Covered Benefits are performed by out-of-Network Provider(s), unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.

Pg#_____ g) A description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;

Pg#_____ h) The criteria by which an Insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(h) shall apply to Carriers, including Dental and Vision Carriers.

Pg#_____ i) The involuntary disenrollment rate among Insureds of the Carrier. 211 CMR 52.13(3)(i) shall apply to Carriers, including Dental and Vision Carriers.

Pg#_____ 1. For the purposes of 211 CMR 52.13(3)(i), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.

Pg#_____ 2. For the purposes of 211 CMR 52.13(3)(i), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.

Pg#_____ j) The requirement that an Insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.13(3)(j)1. through 5. 211 CMR 52.13(3)(j) shall apply to Carriers, including Dental and Vision Carriers.

Pg#_____ 1. failure by the insured or other responsible party to make payments required under the contract;

Pg#_____ 2. misrepresentation or fraud on the part of the Insured;

Pg#_____ 3. commission of acts of physical or verbal abuse by the Insured which pose a threat to Providers or other Insureds of the Carrier and which are unrelated to the physical or mental condition of the Insured; provided, that the Commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3.;

Pg#_____ 4. relocation of the Insured outside the service area of the carrier; or

Pg#_____ 5. non-renewal or cancellation of the group contract through which the Insured receives coverage;

Pg#_____ k) A description of the Carrier's, including a Dental or Vision Carrier's, method for

resolving Insured Inquiries and Complaints. For a Health Benefit Plan, this description shall include a description of the internal Grievance process and the external review process consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*, including a description of the process for seeking expedited internal review and concurrent expedited internal and external reviews pursuant to 958 CMR 3.000;

Pg#_____ l) A statement telling Insureds how to obtain the report regarding Grievances pursuant to 958 CMR 3.600(1)(d) from the Office of Patient Protection;

Pg#_____ m) A description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and Internet Website;

Pg#_____ n) A summary description of the procedure, if any, for out-of-Network referrals and any additional charge for utilizing out-of-network Providers. 211 CMR 52.13(3)(n) shall apply to Carriers, including Dental and Vision Carriers;

Pg#_____ o) A summary description of the Utilization Review procedures and quality assurance programs used by the Carrier, including a Dental or Vision Carrier, including the toll-free telephone number to be established by the Carrier that enables consumers to determine the status or outcome of Utilization Review decisions;

Pg#_____ p) A statement detailing what translator and interpretation services are available to assist Insureds, including that the Carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non- English languages in Massachusetts, 211 CMR 52.13(3)(p) shall apply to Carriers, including Dental and Vision Carriers.

Pg#_____ q) A list of prescription drugs excluded from any closed or restricted formulary available to Insureds under the Health Benefit Plan; provided, that the Carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary. A Carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the Carrier does all of the following:

Pg#_____ 1. provides a complete list of prescription drugs that are included in any closed or restricted formulary;

Pg#_____ 2. clearly states that all other prescription drugs are excluded;

Pg#_____ 3. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

Pg#_____ 4. provides an Internet Website that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and

Pg#_____ 5. clearly states that there shall be no financial penalty for a patient's choice to receive a lesser quantity of any opioid contained in schedule II or III of M.G.L. c. 94C, § 3, and lists each of such schedule II or III drugs.

Pg#_____ r) A summary description of the procedures followed by the Carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

Pg#_____ s) Requirements for continuation of coverage mandated by state and federal law;

Pg#_____ t) A description of coordination of Benefits consistent with 211 CMR 38.00: *Coordination of Benefits (COB)*;

Pg#_____ u) A description of coverage for emergency care and a statement that Insureds have the opportunity to obtain Health Care Services for an Emergency Medical Condition,

including the option of calling the local pre-hospital emergency medical service system, whenever the Insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

Pg#_____ v) If the Carrier offers services through a Network or through Participating Providers, the following statements regarding continued treatment:

Pg#_____ 1. If the Carrier allows or requires the designation of a Primary Care Provider, a statement that the Carrier will notify an Insured at least 30 Days before the disenrollment of such Insured's Primary Care Provider and shall permit such Insured to continue to be covered for Health Services, consistent with the terms of the Evidence of Coverage, by such Primary Care Provider for at least 30 Days after said Provider is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative Primary Care Provider.

Pg#_____ 2. A statement that the Carrier will allow any female Insured who is in her second or third trimester of pregnancy and whose Provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said Provider, consistent with the terms of the Evidence of Coverage, for the period up to and including the Insured's first postpartum visit.

Pg#_____ 3. A statement that the Carrier will allow any Insured who is Terminally Ill and whose Provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said Provider, consistent with the terms of the Evidence of Coverage, until the Insured's death.

Pg#_____ 4. A statement that the Carrier will provide coverage for Health Services for up to 30 Days from the effective date of coverage to a new Insured by a Provider who is not a Participating Provider in the Carrier's Network if:

Pg#_____ a. the Insured's employer only offers the Insured a choice of Carriers in which said Provider is not a Participating Provider; and

Pg#_____ b. said Provider is providing the Insured with an ongoing course of treatment or is the Insured's Primary Care Provider; and

Pg#_____ c. With respect to an Insured in her second or third trimester of pregnancy, 211 CMR 52.13(3)(v)4. shall apply to services rendered through the first postpartum visit. With respect to an Insured with a Terminal Illness, 211 CMR 52.13(3)(v)4. shall apply to services rendered until death;

Pg#_____ 5. A Carrier may condition coverage of continued treatment by a Provider under 211 CMR 52.13(3)(v)1. through 4. upon the Provider's agreeing as follows:

Pg#_____ a. to accept reimbursement from the Carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose Cost Sharing with respect to the Insured in an amount that would exceed the Cost Sharing that could have been imposed if the Provider had not been disenrolled;

Pg#_____ b. to adhere to the quality assurance standards of the Carrier and to provide the Carrier with necessary medical information related to the care provided; and

Pg#_____ c. to adhere to the Carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing

services pursuant to a treatment plan, if any, approved by the Carrier;

Pg#_____ 6. Nothing in 211 CMR 52.13(3)(v) shall be construed to require the coverage of Benefits that would not have been covered if the Provider involved remained a Participating Provider;

Pg#_____ w) If a Carrier requires an Insured to designate a Primary Care Provider, a statement that the Carrier will allow the Primary Care Provider to authorize a standing referral for specialty health care provided by a Health Care Provider participating in the Carrier's Network when:

Pg#_____ 1. the Primary Care Provider determines that such referrals are appropriate;

Pg#_____ 2. the Provider of specialty health care agrees to a treatment plan for the Insured and provides the Primary Care Provider with all necessary clinical and administrative information on a regular basis; and

Pg#_____ 3. the Health Care Services to be provided are consistent with the terms of the Evidence of Coverage.

Nothing in 211 CMR 52.13(3)(w) shall be construed to permit a Provider of specialty health care who is the subject of a referral to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;

Pg#_____ x) If a Carrier requires an Insured to obtain referrals or prior authorization from a Primary Care Provider for specialty care, a statement that the Carrier will not require an Insured to obtain a referral or prior authorization from a Primary Care Provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such Carrier's Health Care Provider Network and that the Carrier will not require higher copayments, coinsurance, deductibles or additional Cost-Sharing features for such services provided to such Insureds in the absence of a referral from a Primary Care Provider:

Pg#_____ 1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be Medically Necessary as a result of such examination;

Pg#_____ 2. maternity care; and

Pg#_____ 3. medically necessary evaluations and resultant Health Care Services for acute or emergency gynecological conditions.

Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an Insured's Primary Care Provider regarding the Insured's condition, treatment, and need for follow-up care; and nothing in 211 CMR 52.13(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;

Pg#_____ y) A statement that the Carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(3)(y), mental health care, by persons with recognized expertise in specialty pediatrics to Insureds requiring such services.

Pg#_____ z) If a Carrier allows or requires an Insured to designate a Primary Care Provider, a statement that the Carrier shall provide the Insured with an opportunity to select a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant as a Primary Care Provider or to change his or her Primary Care Provider to a

Pg#_____ Participating Provider Nurse Practitioner or a Participating Provider Physician

Pg#_____ Assistant at any time during the Insured's coverage period.

(aa) Evidence that the Carrier will provide coverage on a nondiscriminatory basis for

covered services when delivered or arranged for by a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant. For the purposes of 211 CMR 52.13(3)(aa), nondiscriminatory basis shall mean that a Carrier's plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a Participating Provider Nurse Practitioner or Participating Provider Physician Assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other Participating Providers, in accordance with M.G.L. c. 176R, § 16(1) and c. 176S, § 1;

Pg#_____ (bb) A statement that the Carrier shall be required to pay for Health Care Services ordered by a treating physician or a Primary Care Provider if the Health Services are a Covered Benefit under the Insured's Health Benefit Plan and the Health Services are Medically Necessary.

REQUIRED DISCLOSURES - For Carriers and Behavioral Health Managers

211 CMR 51.14(1):

A Carrier shall provide to at least one adult Insured in each household upon enrollment, and to a prospective Insured upon request, the following information:

Pg#_____ (a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;

Pg#_____ (b) a summary description of the process by which clinical guidelines and Utilization Review criteria are developed;

Pg#_____ (c) the voluntary and involuntary disenrollment rate among Insureds of the Carrier;

Pg#_____ 1. For the purposes of 211 CMR 52.14(1)(c), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

Pg#_____ 2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an Insured has terminated coverage with the Carrier by nonpayment of premium.

Pg#_____ 3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.

Pg#_____ (d) a notice to Insureds regarding Emergency Medical Conditions that states all of the following:

Pg#_____ 1. that Insureds have the opportunity to obtain Health Care Services for an Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the Insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services.

Pg#_____ 2. that no Insured shall in any way be discouraged from using the local pre hospital emergency medical service system, the 911 telephone number, or the local equivalent;

Pg#_____ 3. that no Insured will be denied coverage for medical and transportation

expenses incurred as a result of such Emergency Medical Condition; and

Pg#_____ 4. if the Carrier requires an Insured to contact either the Carrier or its designee or the Primary Care Provider of the Insured within 48 hours of receiving emergency services, that notification already given to the Carrier, designee or Primary Care Provider by the attending emergency Provider shall satisfy that requirement.

Pg#_____ (e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the Insured or prospective Insured from the Office of Patient Protection; and

(f) a statement:

Pg#_____ 1. that an Insured has the right to request referral assistance from a Carrier if the Insured or the Insured's Primary Care Provider has difficulty identifying Medically Necessary services within the Carrier's Network;

Pg#_____ 2. that the Carrier, upon request by the Insured, shall identify and confirm the availability of these services directly; and

Pg#_____ 3. that the Carrier, if necessary, shall obtain or arrange for Out-of-network services if they are unavailable within the Network.

Pg#_____ **211 CMR 52.14(2):**

The information required of Carriers by 211 CMR 52.14(1)(a) through (f) may be contained in the Evidence of Coverage and need not be provided in a separate document.

Pg#_____ **211 CMR 52.14(3):**

Every disclosure required of Carriers and described in 211 CMR 52.14(1)(a) through (f) must contain the effective date, date of issue and, if applicable, expiration date.

211 CMR 52.14(4):

Pg#_____ A Carrier must maintain a toll-free telephone number and website available to Insureds to present Provider cost information to Insureds that meets the following requirements:

Pg#_____ (a) the Insured may request and obtain the following, in real time:

Pg#_____ 1. the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and

Pg#_____ 2. the estimated amount the Insured will be responsible to pay for a proposed admission, procedure or service that is a Medically Necessary Covered Benefit, based on the information available to the Carrier at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other Cost-sharing requirements for any Covered Benefits;

Pg#_____ (b) notwithstanding anything to the contrary in 211 CMR 52.14(4)(a), the Insured shall not be required to pay more than the disclosed amounts for the Covered Benefits that were actually provided;

Pg#_____ (c) nothing in 211 CMR 52.14(4) shall prevent a Carrier from imposing Cost-sharing requirements disclosed in the Insured's Evidence of Coverage for unforeseen services that arise out of the proposed admission, procedure or service;

Pg#_____ (d) the Carrier must alert the Insured that these are estimated costs, and that the actual amount the Insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

211 CMR 52.14(5):

To provide information to Insureds about the disposition of Provider claims submitted to the Carrier, the Carrier shall issue to Insureds the summary of payments form, as authorized by the Commissioner, and the form shall be issued to the individual Insured rather than to the subscriber, and the form may be issued in paper or through an Internet Website, provided that a Carrier will issue the form by paper upon request by the Insured.

Please confirm the carrier understands their responsibilities noted above.

_____

211 CMR 52.14(6):

Carriers shall submit Material Changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 Days before their effective dates.

Please confirm the carrier understands their responsibilities noted above.

_____

211 CMR 52.14(7):

Carriers shall submit Material Changes to the disclosures required by 211 CMR 52.14(1)(a) through (f) to at least one adult Insured in every household residing in Massachusetts at least once every two years.

Please confirm the carrier understands their responsibilities noted above.

_____

211 CMR 52.14(9):

A Carrier, including a Dental or Vision Carrier, shall provide to a health, Dental or Vision Care Provider, a written reason or reasons for denying the application of any health, Dental, or Vision Care Provider who has applied to be a Participating Provider.

Please confirm the carrier understands their responsibilities noted above.

_____

Please advise whether your company contracts with a "behavioral health manager" in administering behavioral health services.

YES ☐ **NO** ☐

If YES, please respond to the following:

Name of Behavioral Health Manager: _____

Regulatory Contact Person and Title: _____

Office Address: _____

Telephone: _____

Facsimile: _____

211 CMR 52.14(10):

A Carrier for whom a Behavioral Health Manager is administering behavioral Health Services shall state on its new enrollment cards issued in the normal course of business, within one year, the name and telephone number of the Behavioral Health Manager.

FORWARD a sample ID Card that includes the name and telephone number of the Behavioral Health Manager.

211 CMR 52.14(11):

A Behavioral Health Manager ("BHM") shall provide the following information to at least one adult Insured in each household covered by their services:

(a) a notice to the Insured regarding emergency mental Health Services that states:

Pg#_____ 1. that the Insured may obtain emergency mental Health Services, including the option of calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if the Insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;

Pg#_____ 2. that no Insured shall be discouraged from using the local pre-hospital emergency medical service system, the 911 emergency telephone number or its local equivalent;

Pg#_____ 3. that no Insured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and

Pg#_____ 4. if the Behavioral Health Manager requires an Insured to contact either the Behavioral Health Manager, Carrier or Primary Care Provider of the Insured within 48 hours of receiving emergency services, notification already given to the Behavioral Health Manager, Carrier or Primary Care Provider by the attending emergency Provider shall satisfy that requirement;

Pg#_____ (b) a summary of the process by which clinical guidelines and Utilization Review criteria are developed for behavioral Health Services; and

Pg#_____ (c) a statement that the Office of Patient Protection is available to assist consumers, a description of the Grievance and review processes available to consumers, and relevant contact information to access the Office of Patient Protection and these processes.

Either (1) FORWARD a copy of the notice highlighting each item and where it may be located within the notice or (2) similarly highlight the page(s) of the Evidence of Coverage that meet the notice requirements.

211 CMR 52.14(12):

The information required of Behavioral Health Managers by 211 CMR 52.14(11) may be contained in the Carrier's Evidence of Coverage and need not be provided in a separate document. Every disclosure described in 211 CMR 52.14(11) shall contain the effective date, date of issue and, if applicable, expiration date.

Provide a statement how the carrier provides the noted information.

_____

_____

211 CMR 52.14(13):
A Behavioral Health Manager shall submit a Material Change to the information required by 211 CMR 52.14(11) to the Bureau at least 30 Days before its effective date and to at least one adult Insured in every household residing in the Commonwealth at least biennially.
Provide a statement to confirm that the carrier/BHM understands their responsibilities.

_____

_____

211 CMR 52.14(15):
A Carrier for whom a Behavioral Health Manager is administering behavioral Health Services shall be responsible for the Behavioral Health Manager's failure to comply with the requirements of 211 CMR 52.00 in the same manner as if the Carrier failed to comply and shall be subject to the provisions of 211 CMR 52.17.
Provide a statement to confirm that the carrier understands their responsibilities.

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_____

DEPENDENT ELIGIBILITY

pg____ **Federal Health Care Reform - Section 2714 of the PHSA/Section 1001 of the PPACA**
Effective September 23, 2010, upon renewal, insurers are required to permit a subscriber to include a child(ren) on a policy that has dependent coverage until age the child(ren) turns age 26. This applies to all plans in the individual market, new employer plans, and existing employer plans, unless the adult child has an offer of coverage through his or her employer.

pg____ **Plant Closing** According to M.G.L. c. 176G, § 4A, there is a 90-day eligibility for continued coverage in the event of a plant closing or partial plant closing.

Divorce or Separation According to M.G.L. c. 176G, § 5A(a)-(b),

pg____ "(a) In the event of the granting of a judgment absolute of divorce or of separate support to which a member of a group health maintenance contract is a party, the person who was the spouse of said member prior to the issuance of such judgment shall be and remain eligible for benefits under said contract, whether or not said judgment was entered prior to the effective date of said contract, without additional premium or examination therefor, as if said judgment had not been entered; provided, however, that such eligibility shall not be required if said judgment so provides. Such eligibility shall continue through the member's participation in the contract until the remarriage of either the member or such spouse, or until such time as provided by said judgment, whichever is earlier.

pg____ (b) In the event of the remarriage of the member referred to in paragraph (a), the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family contract or the issuance of an individual contract, either of which may be at additional premium rates determined by the commissioner of insurance to be just and reasonable in accordance with the additional insuring risks involved."

pg____ **Small Group**. There must be a provision for continuation of coverage for any individual, general, blanket or group policy of health, accident and sickness insurance ***(excludes supplements to Medicare or other governmental programs)*** if sold to an eligible small business or group with between 2-19 employees and the provisions for continuation of coverage should be in compliance with M.G.L. c. 176J, § 9.

pg____ **Group Health Care Insurers.** According to 940 CMR 9.04, it shall be considered an unfair and deceptive act or practice in violation of M.G.L. c. 93A, § 2, for a carrier to deny a member's claim for covered health care services on the grounds that, prior to the date covered health care

services were received, the employer's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the member prior to the date the covered health care services were received in the manner set forth in 940 CMR 9.05.

MANDATED BENEFITS

According to 211 CMR 52.13(3)(a), evidences of coverage shall contain a clear, concise and complete statement of the health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law as follows:

Requirements for emergency services provided to members for emergency medical conditions

pg____ According to M.G.L. c. 176G, § 5(b), "[a] health maintenance organization shall cover emergency services provided to members for emergency medical conditions. After the member has been stabilized for discharge or transfer, the health maintenance organization or its designee may require a hospital emergency department to contact the physician on-call designated by the health maintenance organization or its designee for authorization of post-stabilization services to be provided. The hospital emergency department shall take all reasonable steps to initiate contact with the health maintenance organization or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if the health maintenance organization or its designee has not responded to said call within 30 minutes…in the event the attending physician and said on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition provided that such treatment is consistent with generally accepted principles of professional medical practice and a covered benefit under the member's evidence of coverage." (See also Bulletin No. 00-14)

pg____ According to M.G.L. c. 176G, § 5(c), "[a] health maintenance organization may require a member to contact either the health maintenance organization or its designee or the primary care provider of the member within 48 hours of receiving such emergency services, but notification already given to the health maintenance organization or to said primary care provider by the attending physician shall satisfy the requirements of this paragraph."

pg____ According to M.G.L. c. 176G, § 5(e), "[a] health maintenance organization shall clearly state in its brochures, contracts, policy manuals and printed materials that members shall have the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever an enrollee is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No member shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of an emergency medical condition."

Mental Health Parity

According to M.G.L. c. 176G, § 4M(a), "[a]A health maintenance contract issued or renewed within or without the commonwealth shall provide mental health benefits on a nondiscriminatory basis to residents of the commonwealth and to all members or enrollees having a principal place of employment in the commonwealth for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM:

(1) schizophrenia;
(2) schizoaffective disorder;
(3) major depressive disorder;
(7) panic disorder;
(8) delirium and dementia;
(9) affective disorders;

(4) bipolar disorder;
(5) paranoia and other psychotic disorders;
(6) obsessive-compulsive disorder;
(10) eating disorders;
(11) post traumatic stress disorder;
(12) substance abuse disorders; and
(13) autism

A health maintenance contract issued or renewed within or without the commonwealth shall provide mental health benefits on a nondiscriminatory basis to residents of the commonwealth and to all members or enrollees having a principal place of employment in the commonwealth for the diagnosis and medically necessary and active treatment of any mental disorder, as described in the most recent edition of the DSM, that is approved by the commissioner of mental health.

pg____ **Rape-Related Mental or Emotional Disorders**. According to M.G.L. c. 176G, § 4M(b), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265 [of the Massachusetts General Laws], whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of M.G.L. c. 258C."

pg____ **Children and Adolescents under the age of 19**. According to M.G.L. c. 176G, § 4M(c), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis to children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to:

(1) an inability to attend school as a result of such a disorder,

(2) the need to hospitalize the child or adolescent as a result of such a disorder,

(3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

The health maintenance organization shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect."

Nondiscriminatory basis - means that copayments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not greater for mental disorders than those required for physical conditions, and office visit copayments are not greater than those required for primary care visits. [refer to Bulletin 2009-04]
Please confirm that all plan designs conform to the above-note Nondiscriminatory requirement.

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pg____ **All Other Mental Disorders**. According to M.G.L. c. 176G, § 4M(e), "[a]ny such health maintenance contract shall also provide benefits for the diagnosis and treatment of all other mental disorders not otherwise provided for in this section and which are described in the most

recent edition of the DSM

"… health insurance coverage offered by an issuer … that provides both medical/surgical and mental health/substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health/substance use disorder benefits … that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification." 45 CFR 146.136 (c) (2)

Carriers may continue, however, to review the medical necessity of treatments and coordinate care in the least restrictive, clinically appropriate setting, provided that the reviews are consistent with state and federal requirements.

pg____ **Psychopharmacological Services and Neuropsychological Assessment Services.** According to M.G.L. c. 176G, § 4M(i), "psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services."

LICENSED MENTAL HEALTH PROFESSIONALS

[M.G.L. c. 175, § 47B(i) (or M.G.L. c. 176A, § 8A(i) or M.G.L. c. 176B, § 4A(i)) -]

pg____ physician who specializes in the practice of psychiatry;
pg____ psychologist;
pg____ independent clinical social worker;
pg____ mental health counselor;
pg____ nurse mental health clinical specialist;
pg____ a licensed alcohol and drug counselor I or
pg____ marriage and family therapist within the lawful scope of practice for such therapist.

Where Services may be Provided. According to M.G.L. c. 176G, § 4M(g), "[b]enefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section:

INPATIENT SERVICES

"[m]ay be provided in
pg____ a general hospital licensed to provide such services,
pg____ in a facility under the direction and supervision of the department of mental health,
pg____ in a private mental hospital licensed by the department of mental health, or
pg____ in a substance abuse facility licensed by the department of public health."

INTERMEDIATE SERVICES

As stated in Bulletin No. 09-11, please include a provision that clearly notes the following: -
"Intermediate Services" - "[a] range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services, include, but are not limited to, the following:

pg____ Acute and other residential treatment;
pg____ Partial hospitalization;
pg____ Day treatment;
pg____ In-home therapy services;
pg____ Clinically managed detoxification services;
pg____ Intensive Outpatient Programs (IOP); and
pg____ Crisis stabilization.

Level of Benefits for Intermediate Care Services

The duration of intermediate care services authorized for any particular individual will vary

according to that person's individual needs. Because Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008 do not specify a minimum benefit for intermediate care, authorizations for intermediate care should be based on medical necessity rather than any arbitrary number of days or number of visits..

Please confirm that the carrier complies with this requirement and highlight the page number where the carrier includes a provision that clearly states this information.

OUTPATIENT SERVICES

"[m]ay be provided in:

pg____ a licensed hospital,

pg____ a mental health or substance abuse clinic licensed by the department of public health,

pg____ a public community mental health center,

pg____ a professional office, or

pg____ home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license."

(See also Bulletin No. 03-11)"

Disclosure. According to M.G.L. c. 176G, § 4M(h), "[n]o health maintenance organization shall require as a condition to receiving benefits mandated by this section consent to the disclosure of information regarding services for mental disorders under different terms and conditions than consent is required for disclosure of information for other medical conditions. A determination by a health maintenance organization that services authorized pursuant to this section are not medically necessary shall only be made by a licensed mental health professional; provided, that this provision shall not be construed as applying to denials of service resulting from an insured's lack of insurance coverage or use of a facility or professional which has not entered into a negotiated agreement with the health maintenance organization. The benefits provided in any health maintenance contract pursuant to this section shall meet all other terms and conditions of the health maintenance contract not inconsistent with this section."

Please confirm that the carrier complies with this requirement.

Access to Services to Treat Substance Use Disorders

[refer to [Bulletin 2015-05; Access to Services to Treat Substance Use Disorders; Issued July 31, 2015]

Access to Acute Treatment Services and Clinical Stabilization Services

pg____ Chapter 258 requires insured health plans[1] offered under M.G.L. chapters 175, 176A, 176B, and 176G (hereinafter referred to as an insured health plan) that are issued, delivered or renewed within the commonwealth and considered creditable coverage under section 1 of chapter 111M to provide coverage for medically necessary acute treatment services and medically necessary clinical stabilization services for at least 14 consecutive days. Medical necessity is to be determined by the treating clinician in consultation with the patient.

pg____ Insured health plans shall cover and shall not require preauthorization for the 14-day period of medically necessary acute treatment and clinical stabilization services (American Society of Addiction Medicine Levels 4, 3.7 and 3.5) for an insured obtaining acute treatment services or clinical stabilization services; as long as the facility providing the noted services provides the carrier with appropriate notification of the admission within 48 hours of admission. Carriers shall not require that any facility provide notification beyond the name of the patient, information regarding the patient's coverage with the carrier's plan and the initial treatment plan that has been developed for the patient.

pg____ Carriers may initiate utilization review procedures on the 7th day of a patient's stay for acute treatment services or the 7th day of a patient's stay for clinical stabilization services, including but not limited to discussions about coordination of care and discussions of treatment plans, but a carrier may not make any utilization review decisions that impose any restriction or deny any future medically necessary acute treatment or clinical stabilization services unless a patient has received at least 14 consecutive days of acute treatment and/or clinical stabilization services. Any such decisions must follow the requirements of M.G.L. c. 176O regarding the transmission of adverse determination notifications to patients and clinicians and processes for internal and external appeals of carrier decisions.

pg____ For plans that provide or arrange for the delivery of care through a closed network of health care providers, acute treatment service and clinical stabilization services delivered by providers who are not part of an insured health plan's closed network of providers are subject to prior authorization procedures unless the health plan's provider network is found to be inadequate to provide access to acute treatment or clinical stabilization services for plan members.

pg____ **Preauthorization Protocols for All Other Substance Use Disorder Services**
Insured health plans issued, delivered or renewed within the Commonwealth, which are considered creditable coverage under section 1 of chapter 111M, shall not require a member or treating clinician to obtain a preauthorization for covered substance use disorder treatment services if the provider is certified or licensed by the Department of Public Health (DPH). Substance use disorder treatment services include early intervention services for substance use disorder treatment, outpatient services, including medically assisted therapies, intensive outpatient and partial hospitalization services, residential or inpatient services, and medically intensive inpatient services. The term provider includes facilities as well as individual practitioners certified or licensed by the DPH.

pg____ If a service is not covered by an insured health plan, a carrier should take all appropriate steps to notify relevant contracting providers and identify that a substance use disorder service is not covered within the insured health plan's benefits.

Identify the system that the carrier has in place to comply with the above.

_____
_____
_____

Treatment of Autism Spectrum Disorders (ASD)

According to M.G.L. c. 176G §4V fully insured health plans **issued or renewed by health insurance carriers on and after January 1, 2011** must provide benefits for the diagnosis and treatment of ASD on a nondiscriminatory basis to all residents of Massachusetts and to all insureds having a principal place of employment in Massachusetts.

pg____ ASD includes any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

pg____ Diagnosis includes medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has an ASD.

pg____ There may be no annual or lifetime dollar or unit of service limitations on coverage for the diagnosis and treatment of ASD that is less than the annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.

pg____ There may not be limits on the number of visits a covered individual may make to an autism services provider.

pg____ There shall not be limits to benefits for the diagnosis and treatment of ASD that are otherwise available to an individual under the health plan.

pg____ Treatment includes the following medically necessary care prescribed, provided or ordered for an individual diagnosed with an ASD by a licensed physician or a licensed psychologist:

pg____ **Habilitative or Rehabilitative Care**: Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including in the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

pg____ **Pharmacy Care**: Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the health plan for other medical conditions.

pg____ **Psychiatric Care**: Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

pg____ **Psychological Care**: Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

pg____ **Therapeutic Care**: Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

INCLUDE THE FOLLOWING DEFINED TERMS

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism services provider: a person, entity or group that provides treatment of autism spectrum disorders.

Autism spectrum disorders: any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board certified behavior analyst: a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Diagnosis of autism spectrum disorders: medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has 1 of the autism spectrum disorders.

Treatment of autism spectrum disorders: includes the following care prescribed, provided or ordered for n individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

Autism Services Providers/Networks - [refer to Bulletin 2010-15]
An autism services provider is a person, entity or group that provides treatment of ASD. This includes:

pg____ board certified behavior analysts,
pg____ psychiatrists, psychologists,
pg____ licensed or certified speech therapists,
pg____ occupational therapists,
pg____ physical therapists, and social workers and pharmacies.

Such providers shall work with populations and in areas within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. A carrier that provides benefits through a network(s) or has contracts with participating providers must provide an adequate network of available ASD providers. Each network must, at a minimum, include board certified behavior analysts who have been credentialed by the Behavior Analyst Certification Board. The network must provide adequate access to all mandated ASD services, including, but not limited to, applied behavior analysis. The network must include sufficient numbers of providers to provide access to all medically necessary habilitative and rehabilitative services for ASD. In the event that a carrier's network does not provide adequate access to ASD providers at any time and such services are unavailable within the network, the carrier must obtain or arrange for out-of-network services as needed.

Please confirm that the carrier conforms to the above-note requirement.

Access/Provider Directory
If any covered autism services provider is not available in a network, information on the way to obtain or arrange for out-of-network services must be provided in a clear and understandable manner. [Bulletin 2010-15]

pg____ **1. Certify that all covered autism services provider are available in the carrier's network, or**
pg____ **2. Identify the way a member may obtain or arrange for out-of-network services in a clear and understandable manner both in the evidence of coverage and provider directory; and**
pg____ 3. **Forward a copy of the information forwarded to members regarding access to out-of-network autism service providers.**

Preventive and Primary Care Services for Children

	Dependent Definition. According to M.G.L. c. 176G, § 4, a dependent includes
pg____	• newborn infants and newborn infants of a dependent of a policyholder domiciled in the commonwealth
pg____	• immediately from the moment of birth and thereafter

pg____	• [and] adoptive children of a policyholder domiciled in the commonwealth . . . immediately from the date of the filing of a petition to adopt . . . and thereafter if the child has been residing in the home of the policyholder . . .
pg____	• as a foster child for whom the holder…has been receiving foster care payments, or,
pg____	• in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of a policyholder . . . and thereafter."
pg____	• if payment of a specific premium is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and payment of the required premium must be furnished to the insurer or indemnity corporation. For the purposes of this section "notification" may mean submission of a claim."
pg____	According to M.G.L. c. 176G, § 4 "[t]he coverage for newly born infants and adoptive children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth."
pg____	According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include those special medical formulas which are approved by the commissioner of the department of public health, prescribed by a physician, and are medically necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria."
pg____	According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include screening for lead poisoning as required by the regulations promulgated pursuant to section one hundred and ninety-three of chapter one hundred and eleven [of the Massachusetts General Laws; 958 CMR 3.000]."
	According to M.G.L. c. 176G, § 4, policies must include coverage for the following services to the dependent child of an insured member from the date of birth through the attainment of six (6) years of age:
pg____	"physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three (3) times during the next year, annually until age six."
pg____	"Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematrocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician."
pg____	According to M.G.L. c. 176G, § 4, policies shall provide "coverage for the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the department of public health." (See also Bulletin No. 98-13)

Preventive health services 45 CFR§147.130

	A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and ***may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible)*** with respect to those items and services:
pg____	(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);
pg____	(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);
pg____	(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Early Intervention

According to M.G.L. c. 176G §4, "[t]he dependent coverage of any such policy shall also provide coverage for medically necessary early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the department of public health and in accordance with applicable certification requirements. Such medically necessary services shall be provided by early intervention specialists who are working in early intervention programs certified by the department of public health, as provided in sections 1 and 2 of chapter 111G, for children from birth until their third birthday. Reimbursement of costs for such services shall be part of a basic benefits package offered by the insurer or a third party and shall not require co-payments, coinsurance or deductibles; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

pg____ **Identify the page number(s) specifically noting that the plan does not include any maximum benefit for early intervention services [see Section 86 of Chapter 27 of the Acts of 2009 and Bulletin 2009-08] nor require co-payments, coinsurance or deductibles [Section 97 of Chapter 131 of the Acts of 2010 and Section 20 of Chapter 409 of the Acts of 2010.**

Hearing Aids For Children

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

pg____ According to M.G.L. c. 176G, § 4N , policies shall provide "[c]overage for any child, 21 years of age or younger…for the cost of 1 hearing aid per hearing impaired ear **up to $2,000 for each hearing aid**…**every 36 months** upon a written statement from the child's treating physician that the hearing aids are necessary regardless of etiology. Coverage under this section shall include

all related services prescribed by a licensed audiologist or hearing instrument specialist…including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the $2,000 limit in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer.

[Section 5 of Chapter 233 of the Acts of 2012 (the "Act"); this act shall apply to all policies, contracts and certificates which are delivered, issued or renewed on or after January 1, 2013]

Treatment for Cleft Lip and Cleft Palate

pg____ According to M.G.L. c. 176G, § 4W (or M.G.L. c. 176I, § 12), policies shall provide coverage for a child under the age of 18 "[t]he cost of treating cleft lip and cleft palate…[t]he coverage shall include benefits for medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services, if such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both. The coverage required…shall be subject to the terms and conditions applicable to other benefits."

[Sections 6 and 7 of Chapter 234 of the Acts of 2012 (the "Act"); this act shall apply to all policies, contracts and certificates which are delivered, issued or renewed within or without the commonwealth on or after January 1, 2013]

Maternity Coverage

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

pg____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits . . . for the expense of prenatal care, childbirth and post partum care to the same extent as provided for medical conditions not related to pregnancy." (See also Bulletin Nos. 97-01 and 96-02)

pg____ According to M.G.L. c. 176G, § 4, policies "shall provide coverage of a minimum of forty-eight [48] hours of in-patient care following a vaginal delivery and a minimum of ninety-six [96] hours of in-patient care following a caesarean section for a mother and her newly born child. Any decision to shorten such minimum coverages shall be made by the attending physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the department of public health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery, and post-delivery care and shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a registered nurse, physician, or certified nurse midwife; and provided, further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider." (See also Bulletin Nos. 97-01 and 96-02)

pg____ According to M.G.L. c. 176G, § 4, "[f]or the purposes of this section [M.G.L. c. 176G, § 4]

attending physician shall include the attending obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child." (See also Bulletin Nos. 97-01 and 96-02)

Infertility Benefits

(Except a policy which provides supplemental coverage to Medicare or other governmental programs and Dioceses)

pg____ According to M.G.L. c. 176G, § 4, policies "shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth . . . [and] 'infertility' shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.

pg____ For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable [see Sections 15 of Chapter 288 of the Acts of 2010].

According to 211 CMR 37.05, "[s]ubject to any reasonable limitations as described in 211 CMR 37.08, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:

pg____ (1) Artificial Insemination (AI) and Intrauterine Insemination (IUI);

pg____ (2) In Vitro Fertilization and Embryo Transfer (IVF-ET);

pg____ (3) Gamete Intra fallopian Transfer (GIFT);

pg____ (4) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;

pg____ (5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility;

pg____ (6) Zygote Intrafallopian Transfer (ZIFT);

pg____ (7) Assisted Hatching; and

pg____ (8) Cryopreservation of eggs.

pg____ According to 211 CMR 37.06, "[I]nsurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs."

According to 211 CMR 37.08 -

(1) No insurer shall impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility.

(2) No insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits.

(3) No insurer shall impose limitations on coverage based solely on arbitrary factors, including but not limited to number of attempts or dollar amounts.

Please confirm that the carrier complies with this requirement.

Hormone Replacement Therapy and Contraceptive Services

(Except contracts purchased by a subscriber that is a church or qualified church-controlled organization as those terms are defined in 26 U.S.C. section 3121(w)(3)(A) and (B))

According to M.G.L. c. 176G, § 4O(a), "[a]ny individual or group health maintenance contract that is issued, renewed or delivered within or without the commonwealth and that provides benefits for outpatient services shall provide to residents of the commonwealth and to persons having a principal place of employment within the commonwealth benefits for

pg____ hormone replacement therapy services for peri and post menopausal women and

pg____ outpatient contraceptive services under the same terms and conditions as for such other outpatient services.

pg____ Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration." (See also Bulletin No. 02-09)

According to M.G.L. c. 176G, § 4O(b) "[a]ny individual or group health maintenance contract that is issued, renewed or delivered within or without the commonwealth and that provides benefits for outpatient prescription drugs or devices shall

pg____ provide benefits for hormone replacement therapy for peri and post menopausal women and…

pg____ outpatient prescription contraceptive drugs or devices that have been approved by the United States Food and Drug Administration under the same terms and conditions as for such other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods, nothing in this section precludes the use of closed or restricted formulary." (See also Bulletin No. 02-09)

Bulletin 2016-03; Federal Requirement that Carriers Cover Certain Contraceptives Without Any Consumer Cost-Sharing; Issued 1/19/16

pg____ The full range of FDA-approved contraceptive methods as specified in guidelines supported by the Health Resources and Services Administration (HRSA) must be covered without cost-sharing. (Section 2713 of the Public Health Service Act (PHS Act), added by the Patient Protection and Affordable Care Act (ACA), as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. Also, the HRSA Guidelines).

Cytologic screening and mammographic examination expense benefits

pg____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense…of cytologic screening and mammographic examination. Said benefits shall be at least equal to the following minimum requirements: (a) in the case of benefits for cytologic screening, said benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and (b), in the case of benefits for mammographic examination said benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for a mammogram on an annual basis for women forty years of age and older."

Bone Marrow Transplants for Breast Cancer

pg____ According to M.G.L. c. 176G, § 4F, "[a]ny group health maintenance contract shall provide coverage for a bone marrow transplant or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease; provided, however, that said person shall meet the criteria established by the department of public health [105 CMR 240.00]."

Federal Mastectomy Mandate

pg____ According to the Women's Health and Cancer Rights Act of 1998, "[a] group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter."

Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients

pg____ According to M.G.L. c. 176G, § 4Q, policies shall provide coverage "for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish [such member's or enrollee's] bone marrow transplant donor suitability. The coverage shall cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health pursuant to section 218 of chapter 111 [of the Massachusetts General Laws]." (See also Bulletin Nos. 01-16 and 01-04) ***Except a policy which provides supplemental coverage to Medicare or other governmental programs***

Cardiac Rehabilitation Coverage

pg____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense of cardiac rehabilitation. Cardiac rehabilitation shall mean multidisciplinary, medically necessary treatment persons with documented cardiovascular disease, which shall be provided in either a hospital or ot setting and which shall meet standards promulgated by the commissioner of public health after reviewing proposals submitted by the Massachusetts Society for Cardiac Rehabilitation, Inc. and a notice and public hearing on the proposed standards. Such standards shall include, but not be limi outpatient treatment which is to be initiated within twenty-six weeks after the diagnosis of such di [105 CMR 143.00]."

(Except a policy which provides supplemental coverage to Medicare or other governmental programs

Hospice Care - [see also 105 CMR 141.00]

pg____ According to M.G.L. c. 176G, § 4L, "[a]ny group health maintenance contract shall provide coverage for hospice services as defined in section 57D of chapter 111 [of the Massachusetts General Laws] during the life of the patient, to terminally ill patients with a life expectancy of six months or less; provided, however, that such services are determined to be appropriate and authorized by the patient's primary care or treating physician and are equivalent to those services provided by a licensed hospice program regulated by the department of public health.

Home Health Care Coverage

According to M.G.L. c. 176G, §4C, ""Home care services", shall mean health care services for a patient provided by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services.

Said services shall include, but not be limited to…

pg____ nursing and physical therapy;
pg____ occupational therapy;
pg____ speech therapy;
pg____ medical social work;
pg____ nutritional consultation;
pg____ the services of a home health aid; and
pg____ the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy. Benefits for home care services shall apply only when such services are medically necessary and provided in conjunction with a physician approved home health services plan."

Speech, Hearing and Language Disorders

pg____ According to M.G.L. c. 176G, § 4N, policies shall provide "for the expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under [the provisions of] chapter 112 [of the Massachusetts General Laws], if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a hospital, clinic or a private office, and if such coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. The benefits provided by this section shall be subject to the same terms and conditions established for any other medical condition covered by such individual or group health maintenance contract." (See also Bulletin No. 01-03)

Non-prescription Enteral Formulas for Home Use

pg____ According to M.G.L. c. 176G, § 4D, "[a] group health maintenance contract shall provide coverage for nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include shall include food products modified to be low protein in an amount not to exceed $5,000 annually for any insured individual." (See Bulletin 2008-16 and Chapter 214 of the Acts of 2008 - AN ACT INCREASING COVERAGE OF NONPRESCRIPTION ENTERAL FORMULAS)

HIV and Hepatitis C Prevention

pg____ According to M.G.L. c. 176G §4U, "[n]o individual or group health maintenance contract shall restrict or discontinue coverage for medically necessary hypodermic syringes or needles, notwithstanding section 27 of chapter 94C. The term "medical necessity" shall be construed in accordance with the guidelines set forth in subsection (b) of section 16 of chapter 176O."

pg____ For plans that do not include a prescription drug benefit, the Division would consider it reasonable for carriers to require a copayment or coinsurance for a 30-day supply of hypodermic syringes or needles that is equal to the copayment or coinsurance required for a primary care office visit. [See also Chapter 172 of the Acts of 2006 & Section 141 of Chapter 451 of the Acts of 2008]

HIV Associated Lipodystrophy Treatment

pg____ According to M.G.L. c. 176G §4CC, polices shall "[p]rovide coverage for medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to, reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injections or fillers for reversal of facial lipoatrophy syndrome…[c]overage shall be subject to a statement from a treating provider that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefit provided by the insurer."
(Refer to Bulletin 2016-14 – "On August 10, 2016, Chapter 233 of the Acts of2016, "An Act Relative to HIV Associated Lipodystrophy Treatment' ("Chapter 233") was signed into law. Chapter 233 is effective as of Tuesday, November 8, 2016.")

Off-Label Use of Drugs for the treatment of Cancer and HIV/AIDS

pg____ According to M.G.L. c. 176G, § 4E, no policy "shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven L [of chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug."

pg____ According to M.G.L. c. 176G, § 4G, no policy "shall exclude coverage of any such drug for HIV/AIDS treatment on the grounds that the off-label use of the drug has not been approved by the federal food and drug administration for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven P of [chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug." (See also Bulletin Nos. 97-09, 96-06, 96-05, and 95-05)

Oral Cancer Therapy

pg____ According to M.G.L. c. 176G, § 4X "[a]ny individual or group health maintenance contract that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis not less favorable than intravenously administered or injected cancer medications that are covered as medical benefits. An increase in patient cost sharing for anticancer medications shall not be allowed to achieve compliance with this section."
[refer to Section 5 of Chapter 403 of the Acts of 2012]

Diabetes Cost Reduction

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

pg____ According to M.G.L. c. 176G, § 4H, policies shall provide "coverage for the following items if such items are within a category of benefits or services for which coverage is otherwise afforded by the contract, have been prescribed by a health care professional legally authorized to prescribe such items and if the items are medically necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes: blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc, tests; urinary protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified diabetes health care provider participating with the health maintenance contract or affiliated with a provider participating with the health maintenance contract."

According to Bulletin No. 00-05, "nondiscriminatory treatment of benefits for diabetes-related services is mandated. The Division will consider a carrier to be in compliance . . . if the mandated services and supplies are covered within the following categories of benefits:

pg____ • **outpatient services**: outpatient diabetes self-management training and education;

pg____ • **laboratory/radiological services**: all laboratory tests and urinary profiles;

pg____ • **durable medical equipment**: blood glucose monitors, voice-synthesizers and visual magnifying aids;

pg____ • **prosthetics**: therapeutic/molded shoes and shoe inserts; and

pg____ • **prescription drugs**: blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications.

For items in the last category, with the exception of an insulin pump, the Division will consider a carrier to be in compliance if a co-payment is applied for no less than a 30-day supply of the mandated item. The Division will consider it to be a violation . . . if a carrier excludes from a particular category any of the above-noted items for diabetics."

Please confirm that the carrier complies with this requirement.

_____

Coverage For Certain Prosthetic Devices

pg____ According to M.G.L. c. 176G, § 4S(a), "[i]ndividual and group health maintenance contracts shall provide coverage for prosthetic devices and repairs. If prosthetic devices are covered as a durable medical equipment benefit, coverage shall be provided under the same terms and conditions that apply to other durable medical equipment covered under the contracts, except as otherwise provided in this section. If prosthetic devices are covered as a stand-alone prosthetic benefit, coverage shall be consistent with the terms and conditions as described in this section."

pg____ (b) In this section, "prosthetic device" shall mean an artificial limb device to replace, in whole or in part, an arm or leg.

pg____ (c) A health maintenance contract shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract.

pg____ (d) A health maintenance contract shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the contract other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract.

pg____ (e) A health maintenance contract may include a reasonable coinsurance requirement for prosthetic devices and repairs, not to exceed 20 per cent of the allowable cost of the prosthetic device or repair, unless all covered benefits applying coinsurance under the plan do so at a higher amount. If the health maintenance contract provides coverage for services from nonparticipating providers, the contract may include a reasonable coinsurance requirement for prosthetic devices and repairs, not to exceed 40 per cent of the allowable cost of the prosthetic device or repair when obtained from a nonparticipating provider, unless all covered benefits applying coinsurance under the plan do so at a higher amount.

pg____ (f) A health maintenance contract may require prior authorization as a condition of coverage for prosthetic devices.

pg____ (g) A health maintenance contract shall only be required to provide coverage for the most appropriate medically necessary model that adequately meets the medical needs of the policyholder.

Scalp Hair Prosthesis for Cancer Patients

pg____ According to M.G.L. c. 176G, § 4J, "[a] group health maintenance contract which provides coverage for any other prosthesis, shall provide coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia; provided, however, that such coverage shall be subclinicalject to a written statement by the treating physician that the scalp hair prosthesis is medically necessary; and provided, further, that such coverage shall be subject to the same limitations and guidelines as other prostheses. (See also Bulletin No. 98-09)

Insurance Coverage of Qualified Clinical Trials

(Except Medicare Supplement Plans or contracts purchased by a subscriber that is a church or qualified church-controlled organization)

pg____ According to M.G.L. c. 176G, § 4P, "[a]ny individual or group health maintenance contract shall provide for the coverage of patient care services furnished pursuant to qualified clinical trials as defined in, and subject to the requirements and limitations of, section 110L of chapter 175 [of the Massachusetts General Laws]." According to M.G.L. c. 175, § 110L(b), "[a]ny policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall cover and reimburse for patient care services provided pursuant to a qualified clinical trial to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial." (See also M.G.L. c. 176A, § 8X or M.G.L. c. 176B, § 4X, and Bulletin No. 02-13)

Long Term Antibiotic Therapy for the Treatment of Lyme Disease

pg____ According to M.G.L. c. 176G, § 4BB(b),a "[c]ontract shall provide coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment. An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration; provided, however, that a drug, including an experimental drug, shall be covered for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration."

(See also Bulletin No. 2016-13 "[o]n July 31, 2016, Chapter 183 of the Acts of 2016, "An Act Relative to Long-Term Antibiotic Therapy for the Treatment of Lyme Disease" ("Chapter 183") was enacted, retroactively effective as of July 1, 2016.)

PRIMARY CARE PROVIDER ASSIGNMENT

According to M.G.L. c. 176G, § 31 (M.G.L. c. 176J, §16); "[t]o the maximum extent possible, every carrier shall "[a]ttribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier."
[Sections 173 and 188 of Chapter 224 of the Acts of 2012 (the "Act"); effective November 4, 2012]

Explain how your company complies with this requirement.

_____

NON-DISCRIMINATION

Victims of Domestic Abuse. According to M.G.L. c. 176G, § 19, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a health maintenance contract based on information that an individual has been a victim of abuse, as defined by section one of chapter two hundred and nine A [of the Massachusetts General Laws]. No health maintenance organization subject to this chapter, and no officer or agent thereof, shall seek information that such person has been a victim of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. The practices prohibited under this section shall include not only those overtly discriminatory but also practices and devices which are fair in form but discriminatory in practice. Nothing in this section shall be construed as creating a special class of insureds who have been victims of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. Any violation of this section shall constitute an unfair method of competition or an unfair or deceptive act or practice in violation of chapters ninety-three A and one hundred and seventy-six D [of the Massachusetts General Laws]."
Please confirm that the carrier complies with this requirement.

_____

Genetic Testing and Privacy Protection. According to M.G.L. c. 176G, § 24, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount of payment of premium or rates charged, in the length of coverage or in any of the terms and conditions of a health maintenance contact based on genetic information as defined in this section. No health maintenance organization subject to the provisions of this chapter and no officer of agent thereof, shall require genetic tests or private genetic information, as defined in this section, as a condition of the issuance or renewal of a health maintenance contract. Any violation of this section shall constitute an unfair method of competition or

deceptive act or practice in violation of chapters 93A and 176D." [also see Bulletin No. 00-16]

Please confirm that the carrier complies with this requirement.

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pg____ **Consumer Choice of Nurse Practitioners** According to M.G.L. c. 176R, "[t]he commissioner and the group insurance commission shall require that all carriers recognize nurse practitioners as participating providers…and shall include coverage on a nondiscriminatory basis to their insureds for care provided by nurse practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

pg____ According to M.G.L. c. 176R §3, "[a] participating provider nurse practitioner practicing within the scope of his license including all regulations requiring collaboration with a physician under section 80B of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured.

pg_____ According to M.G.L. c. 176R §4, "[n]otwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change its primary care provider to a participating provider nurse practitioner at any time during their coverage period.

pg_____ According to M.G.L. c. 176R §5, "[n]otwithstanding any general or special law to the contrary, a carrier shall ensure that all participating provider nurse practitioners are included on any publicly accessible list of participating providers for the carrier.

MANDATED COVERAGE FROM CERTAIN TYPES OF PROVIDERS

pg____ **Certified Registered Nurse Anesthetist and Nurse Practitioner**. According to M.G.L. c. 176G, § 4, policies shall provide benefits "for services rendered by a certified registered nurse anesthetist or nurse practitioner designated as such certified registered nurse anesthetist or nurse practitioner by the board of registration in nursing pursuant to the provisions of section eighty B of chapter one hundred and twelve; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the board of registration in nursing; and (2) the policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth."

pg____ **Consumer Choice of Physician Assistant Services.** According to M.G.L. c. 176S carriers "[s]hall include coverage on a nondiscriminatory basis to their insureds for care provided by physician assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a physician

assistant who is a participating provider and is practicing within the scope of his or her professional authority as defined by statute, rule and physician delegation to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth."

pg____ • A carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider physician assistant as a primary care provider.

pg____ • A carrier shall ensure that all participating provider physician assistants are included on any publicly accessible list of participating providers for the carrier.

Highlight the section of the certificate that addresses the above-noted requirements.
[See Sections 216 of Chapter 224 of the Acts of 2012 (the "Act"); this act shall apply to all policies, contracts and certificates on or after November 4, 2012]

pg____ **Podiatrist.** According to M.G.L. c. 176G §1, "[a]ny individual who has entered into a group health maintenance contract that provides for any podiatric medical or surgical service which is within the lawful scope of practice of a licensed podiatrist, shall be entitled to such services whether the service is performed by a physician or licensed podiatrist, including authorized referral services on a nondiscriminatory basis."

Bulletin 2016-01; Federal Requirement that Carriers Cover Certain Tobacco Cessation Products Without Consumer Cost Sharing - Tobacco Cessation Products

pg____ The ACA requires coverage, with no cost-sharing, for certain evidence-based preventive items and services given a rating of "A" or "B" by the U.S. Preventive Services Task Force ("USPSTF").

pg____ The USPSTF indicate that clinicians should screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco.

pg____ Screening and tobacco interventions are required to be covered without cost-sharing and that plan benefits should not include any blanket benefit exclusions or limitations that apply to tobacco cessation items or services.

Tobacco Cessation Products

HHS has issued guidance that identifies the following types of tobacco cessation products as items that it believes are appropriate for smoking cessation:

pg____ Nicotine gum,
pg____ Nicotine patch,
pg____ Nicotine lozenge,
pg____ Nicotine oral or nasal spray,
pg____ Nicotine inhaler,
pg____ Bupropion, and
pg____ Varenicline

The Division would consider a health plan to be in compliance with the preventive care requirements of the ACA relative to tobacco cessation products if the health plan's drug benefit includes at least one product within each of the above-noted tobacco cessation product types without cost-sharing (e.g., the health plan's drug benefit includes coverage, without cost sharing, for at least one nicotine gum, one nicotine patch, one nicotine lozenge, etc.). Coverage requirements pertain to both over-the-counter and prescription products.

pg____ Covered persons should be "[g]iven access to at least one of the tobacco cessation products without prior authorization and the managed care methods are consistent with all state and federal laws. Whenever carriers make an adverse determination that denies or limits access to a requested product based on medical necessity criteria, they must provide all necessary notifications to patients and providers and follow all appropriate procedures for internal and external appeals.

Bulletin 2016-05; Federal Requirement that Carriers Cover Certain Lactation Services Without Any Consumer Cost-Sharing

Federal Rules for Preventive Health Care Services

pg____ "Section 2713 of the Public Health Service Act, as amended by the ACA…[r]equire that non-grandfathered insured health plans in the individual and group markets provide benefits, without cost-sharing (*i.e.*, copayments, coinsurance or deductibles) for certain preventive items and services listed in the current recommendations of the United States Preventive Services Task Force, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, and in specific guidelines supported by the Health Resources and Services Administration ("HRSA")."

pg____ **Coverage for Lactation Support and Counseling (*or* Lactation Services)**
"[s]specific guidelines associated with lactation support, supplies and counseling. Carriers must cover comprehensive prenatal and postnatal lactation support, counseling and equipment purchase and/or rental as preventive care services, but may use reasonable medical management techniques to control costs and promote efficient delivery of care."
In accordance with 45 CFR §147.130(a)(2), if a lactation item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such lactation item or service, then a Carrier *may not* impose cost-sharing requirements with respect to the office visit. If a lactation item or service is not billed separately (or is not traced as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of the lactation item or service, then a Carrier *may* impose cost-sharing requirements with respect to the office visit.

pg____ In FAQ Part XXIX, the Departments clarify that coverage for comprehensive prenatal and postnatal lactation support, supplies, and counseling includes lactation counseling as long as the service is performed by a provider acting within the scope of his or her license or certification under applicable state law. Carriers may limit coverage without cost-sharing to a network of providers. However, if a Carrier does not have providers in its network who can provide lactation counseling services, then the Carrier must cover the items or service when performed by an out-of-network provider and not impose cost-sharing with respect to the lactation items or services. Moreover, coverage for lactation support services and items without cost-sharing must extend for the duration of the breastfeeding, and it may not be limited to services provided on an in-patient basis.

pg____ According to FAQ Part XXIX, Carriers must provide information to covered persons about lactation counseling providers available under the Carriers' plans. In order to update their managed care accreditation files, Carriers will need to submit information to the Division that identifies the lactation counseling providers within their networks or that explains that services provided for lactation counseling will be covered by non-network providers without cost-sharing until a Carrier has established contracts to include an adequate number of lactation counseling providers within its networks.

Rehabilitative and Habilitative Services and Devices within Insured Health Benefit Plans
[Filing Guidance 2016-D]

Filings for insured health benefit plans utilizing the Massachusetts Essential Health Benefits Benchmark Plan that are intended to be offered on and after January 1, 2017 should be consistent with the provisions of 45 CFR 156.115(a)(5)(i) – (iii), including the following:

pg____ • benefits for habilitative services and devices are to include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living and may include, for example, therapy for a child who is not walking or talking at the expected age, as well as physical and occupational therapy, speech-language pathology and other services for persons with disabilities in a variety of inpatient and/or outpatient settings;

pg____ • coverage for habilitative services and devices is not limited in a manner that is less favorable than any such limits imposed on coverage for rehabilitative services and devices; and

pg____ • there are not any combined limits on habilitative and rehabilitative services and devices.

pg____ • In addition, the Division would not consider any plan provisions to be appropriate that:

pg____ • discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; or

• apply annual or lifetime dollar limits to any habilitative and rehabilitative services and

devices. (Annual or lifetime limits may be converted to actuarially equivalent treatment or service limitations.)"

Please confirm that the carrier complies with this requirement.

AN ACT ESTABLISHING THE CHILDHOOD VACCINE PROGRAM

pg____ Every surcharge payor [pursuant to section 64 of chapter 118E], to the extent not preempted by federal law, shall provide benefits for: (i) routine childhood immunizations for residents of the commonwealth; and (ii) immunizations for residents of the commonwealth who are 19 years of age and older according to the most recent schedules recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. These benefits shall be exempt from any copayment, coinsurance, deductible or dollar limit provisions in the health insurance policy or contract.

Highlight the section of the certificate that addresses the above-noted Department of Public Health requirements. [See Section 1 of Chapter 28 of the Acts of 2014 (the "Act") that inserts Section 24N (M.G.L. c. 111, §24N(f)). This section of the act shall take effect June 30, 2014].

REQUIREMENTS FOR PROVIDER DIRECTORIES

In addition to Provider directory requirements under 211 CMR 152.08: *Provider Directories for Limited, Regional and Tiered Provider Network Plans*, if applicable:

211 CMR 52.15(1):

_____ A Carrier shall deliver a Provider directory to at least one adult Insured in each household upon enrollment and to a prospective or current Insured upon request. Annually, thereafter, a Carrier shall deliver to at least one adult Insured in each household, or in the case of a group policy, to the group representative, a Provider directory. The Carrier may deliver a Provider directory through an Internet Website, provided that any Provider directory available through an Internet Website be updated at least on a monthly basis.

_____ (a) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its Internet Website for each such Provider:

_____ 1. The method used to compensate or reimburse such Provider, including details of measures and compensation percentages tied to any Incentive Plan or pay for performance provision;

_____ 2. the Provider price relativity, as defined in and reported under M.G.L. c. 12C, § 10;

_____ 3. the Provider's health status adjusted total medical expenses, as defined in and reported under M.G.L. c. 12C, § 10; and

_____ 4. current measures of the Provider's quality based on measures from the Standard Quality Measure Set, as defined in 957 CMR 4.00: *Uniform Provider Reporting of the Standard Quality Measure Set* promulgated by the Center for Health Information and Analysis established by M.G.L. c. 12C, § 2; provided, that the Carrier shall prominently promote Providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.

_____ a. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a Carrier and a Provider.

_____ b. If any specific Providers or type of Providers requested by an Insured are not available in said Network, or are not a covered benefit, or if any Primary Care Provider or behavioral health or substance use disorder Health Care Professional is not accepting new patients, such information shall be provided in an easily obtainable manner, including in the Provider directory.

_____ c. Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants are included and displayed in a nondiscriminatory manner on any publicly accessible list of Participating Providers for the Carrier.

_____ (b) The Provider directory must contain a toll-free number that Insureds can call to determine whether a particular Health Care Provider is affiliated with the Carrier.

_____ (c) The Provider directory must contain an Internet Website address or link that Insureds can visit to determine whether a particular Provider is affiliated with the Carrier.

_____ (d) The Carrier must be able to demonstrate compliance with the following:

1. The Carrier has issued and delivered written notice to the Insured that includes:

_____ a. All necessary information and a clear explanation of the manner by which Insureds can access their specific Provider directory through an Internet Website;

_____ b. A list of the specific information to be furnished by the Carrier through an Internet Website;

_____ c. The significance of such information to the Insured;

_____ d. The Insured's right to receive, free of charge, a paper copy of the Provider directory at any time;

_____ e. The manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and

_____ f. A toll-free number for the Insured to call with any questions or requests.

FORWARD A COPY OF THE WRITTEN NOTICE HIGHLITING WITHIN THE DOCUMENT COMPLIANCE WITH THE LISTED ITEMS ABOVE.

_____ 2. The Carrier has taken reasonable measures to ensure that the information and documents furnished in an Internet Website is substantially the same as that contained in its paper documents.

_____ 3. All notice and time requirements applicable to Evidences of Coverage shall apply to information and documents made available by internet. Information contained in the documents furnished in an Internet Website shall include the effective date and the published date of any updates, modifications or Material Changes.

_____ 4. The Carrier updates the Internet Website as soon as practicable, and at least monthly.

_____ 5. In the case of a group policy, the Carrier delivers a paper copy of the Provider directory to the group representative.

_____ 6. The Carrier has taken reasonable measures to ensure that it furnishes, upon request of the Insured, a paper copy of the Provider directory.

211 CMR 52.15(2):

A Carrier shall not be required to deliver a Provider directory upon enrollment if a Provider directory is delivered to the prospective or current Insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

Please confirm that the carrier complies with this requirement.

211 CMR 52.15(3):

If delivering a paper copy of the Provider directory, a Carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the Carrier:

(a) provides to at least one adult Insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the Provider directory originally provided under 211 CMR 52.15(1); and

(b) updates its toll-free number within 48 hours and Internet Website as soon as practicable.

Please confirm that the carrier complies with this requirement.

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211 CMR 52.15(4):

Every Provider directory described in 211 CMR 52.15 must contain the effective date, date of issue and expiration date if applicable, and reference to any government-sponsored website(s) providing quality and cost information, as may be designated by the Commissioner.

Highlight where the effective date, date of issue and expiration date along with government website is located within the directory.

DIRECT PRIMARY CARE PRACTICE/CONCIERGE MEDICINE

Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to:

1) confirm that the carrier monitors its network of providers;
2) confirm whether the carrier's network includes network providers that require patients to pay an annual fee as a condition for inclusion within that provider's panel of patients
3) if the network includes such providers, confirm that the carrier has amended its provider directory(ies) to clearly identify those providers that will be unavailable to its members who do not or cannot pay the annual fee to be part of the providers' panel and highlight the page(s) that such information may be located within the directory(ies);"
4) Include with the filing a document that lists those contracted providers that charge an annual fee to members as a condition to continue to be a part of the providers' panel of patients.
5) Confirm that the carrier will continue to monitor its network and will advise the Division as necessary regarding contracted providers that charge an annual fee as described above.

Please attach a separate document that addresses each noted item above to consider the filing complete.

BEHAVIORAL HEALTH PROVIDER TYPES

As noted in Bulletin No. 02-07, in meeting the provisions of Chapter 80 of the Acts of 2000 ("Chapter 80"), carriers are to provide or arrange for the "full range of mandated services, including specific treatment modalities appropriate for all ages of patients and all types of covered mental conditions." In addition, it is noted that carriers are to have "sufficient numbers of providers available in the network so that no patient must wait a medically inappropriate amount of time to receive care for acute conditions" and that "care is being delivered promptly and appropriately and that insureds are being provided adequate access as required by law." In order to satisfy the provisions of Chapter 80 and Bulletin No. 02-07, it would appear that provider directories should include lists that address at least the following types of behavioral health providers:

pg____ (a) general behavioral health providers;
pg____ (b) child/pediatric and adolescent behavioral health providers;
pg____ (c) geriatric behavioral health providers;
pg____ (d) substance abuse providers or addictionologists; and
pg____ (e) eating disorder specialists.

pg____ According to Chapter 80, carriers are required to provide or arrange for "a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting . . . inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, or a professional office, or through home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his [or her] license."

pg____ Consistent with the requirements of 211 CMR 52.15(1)(a), indicate next to each provider in the directory their professional licensure designation(s) and clarify with footnotes or other prominent notes whether providers are or are not taking new patients and if they only see patients in certain settings (for example, in an inpatient or intermediate care setting).

INTERNET WEBSITES - 211 CMR 52.13(4)

Please advise whether your company's delivery system for evidences of coverage is an internet website.

YES☐ NO☐

If YES, please respond to the following:
Check the following products for which the evidence of coverage is made available electronically:

☐ **MEDICAL**
☐ **MENTAL HEALTH/SUBSTANCE ABUSE**
☐ **PHARMACY**
☐ **DENTAL**
☐ **VISION**
☐ **OTHER [specify]_____**

If the carrier, including any dental or vision carrier, refers the insured to resources where the information described in the evidence of coverage can be accessed, including, but not limited to, an internet website, such carrier must be able to demonstrate compliance with the following with respect to the internet website, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The carrier has issued and delivered written notice to the insured that includes:

_____ 1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;
_____ 2. A list of the specific information to be furnished by the carrier through an internet website;
_____ 3. The significance of such information to the insured;
_____ 4. The insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;
_____ 5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and
_____ 6. A toll-free number for the insured to call with any questions or requests.

_____ **1) Forward sample copy(ies) of the notice(s) highlighting the requirements noted within 211 CMR 52.13(4)(a)(1-6).**
_____ **2) Forward sample copy(ies) of the website address(es) and documents appearing on its website(s) highlighting the provisions that are substantially the same as those required in its paper documents.**

(b) The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to evidences of coverage shall apply to information and documents furnished by an internet website.
(c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.

Include a statement that confirms the carrier has read items b&c and are in compliance with these provisions.

Group Plans 211 CMR 52.13(5)

A Carrier, including a Dental and Vision Carrier, shall always deliver at least one Evidence of Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 52.14 or 52.15.

Include a statement that confirms the carrier has read the above and is in compliance with the provision.

General Notice of Material Changes 211 CMR 52.13(6)

A Carrier, including a Dental and Vision Carrier, shall provide to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all Material Changes to the Evidence of Coverage.

Include a statement that confirms the carrier has read the above and is in compliance with the provision.

Advance Notice of Material Modifications 211 CMR 52.13(7)

A Carrier, including a Dental or Vision Carrier, shall issue and deliver to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health, Dental or Vision Plan, at least 60 Days before the effective date of the modifications. Such notices shall include the following:

a) any changes in Clinical Review Criteria; and
b) a statement of the effect of such changes on the personal liability of the Insured for the ost of any such changes.

Include a statement that confirms the carrier (1) is in compliance and (2) highlight the page and section of the evidence of coverage that includes a statement that addresses the above.

Advance Filing of Evidence of Coverage. CMR 52.13(8)

A Carrier, including a Dental or Vision Carrier, shall submit all Evidences of Coverage to the Bureau at least 30 Days prior to their effective dates.

Include a statement that confirms the carrier has read the above and understands their responsibilities.

Dates Required. CMR 52.13(9)

Every Evidence of Coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

Include a statement that confirms the carrier has read the above and certify that the evidence of coverage includes this information as well as the location of such information.

NETWORK ADEQUACY (211 CMR 52.12)

According to 211 CMR 52.12(1), "[a] Carrier offering a plan(s) that includes a Network(s) shall maintain such Network(s) such that it is adequate in numbers and types of Providers to assure that all covered services will be accessible to Insureds without unreasonable delay. Adequacy shall be determined in accordance with the requirements of this 211 CMR 52.12, and shall be established by reference to reasonable criteria used by the Carrier, which shall include, but not be limited to, the reasonableness of cost-sharing in relation to the Benefits provided. In any case where the Carrier has an inadequate number or type of Participating Provider(s) to provide services for a Covered Benefit, the Carrier shall ensure that the Insured receives the Covered Benefit at the same benefit level as if the Benefit was obtained from a Participating Provider, or shall make other arrangements acceptable to the Commissioner."

211 CMR 52.12(2)

In accordance with 211 CMR 52.05(3) and (4), a Carrier shall file with the Commissioner an access analysis that meets the requirements of 211 CMR 52.12 for each plan that includes a Network that the Carrier offers in the Commonwealth. The Carrier shall also prepare an access analysis prior to offering a plan that includes a Provider Network, and shall update an existing access analysis whenever the Carrier makes any Material Change to such an existing plan. The access plan shall describe or contain at least the following:

pg____ (a) The Carrier's Network(s);

pg____ (b) A summary of the Carrier's Network adequacy standards;

pg____ (c) The Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the Network(s) to meet the health care needs of populations that enroll in plans with Provider Networks;

pg____ (d) The Carrier's efforts to address the ability of the Network(s) to meet the needs of Insureds with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with disabilities;

pg____ (e) The Carrier's methods for assessing the health care needs of Insureds, including but not limited to the Insureds' needs set forth in 211 CMR 52.12(2)(d), and the Insureds' satisfaction with services in relation to the development of the Network(s);

pg____ (f) The Carrier's methods for monitoring the ability of Insureds to access services out-of- Network;

pg____ (g) A report developed using a Network accessibility analysis system such as GeoNetworks, which shall include the following, or, for Carriers in a new geographic area(s) or an area(s) that does not currently have Insureds, estimates for the following, as applicable;

pg____ 1. maps showing the residential location of Insureds in Massachusetts, Primary Care Providers for both adults and children, specialty care practitioners, and institutional Providers;

pg____ 2. the Carrier's Network adequacy standards;

pg____ 3. geographic access tables illustrating the geographic relationship between Providers and Insureds, or for proposed plans or Service Areas, the population according to the Carrier's standards for every city and town, including at a minimum:

pg____ a. The total number of Insureds, if applicable;

pg____ b. The total number of Network Primary Care Providers who are accepting new patients;

pg____ c. The total number of Network Primary Care Providers who are not accepting new patients;

pg____ d. The total number of Network Health Care Professionals who specialize in the treatment of behavioral health and substance use disorders who are accepting new patients;

pg____ e. The total number of Network Health Care Professionals who specialize in the treatment of behavioral health and substance use disorders but are not accepting new patients;

pg____ f. The total number of Network Health Care Professionals who specialize in the top five types of specialty care by volume of utilization who are accepting new patients;

pg____ g. The total number of Network Health Care Professionals who specialize in the top five types of specialty care by volume of utilization who are not accepting new patients;

pg____ h. The total number of Network inpatient hospitals that provide treatment for acute and tertiary care;

pg____ i. The total number of Network inpatient hospitals that provide treatment for behavioral health and substance use disorders;

pg____ j. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to Primary Care Providers;

pg____ k. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to behavioral health and substance use disorder Health Care Professionals Practitioners:

pg____ l. The percentage of Insureds, meeting the Carrier's standard(s) for access through its Network to specialty care Health Care Professionals;

pg____ m. The percentage of Insureds meeting the Carrier's standard(s) for access throughits Network to inpatient behavioral health and substance use disorder treatment;

pg____ n. The percentage of the number of Insureds meeting the Carrier's standard(s) for access through its Network to inpatient acute tertiary care.

(h) If, at any time, the Carrier becomes aware of changes to the numbers of Health Care Professionals or Providers within its Network that would cause the Carrier to not meet any of its standard(s) for access, then within 30 Days of becoming aware the Carrier will submit a corrective action plan for the Commissioner's review and approval that will identify the steps that the Carrier will take to address the geographic areas where it is not meeting its standard(s) and how the Carrier plans to address access to care in those areas until Network changes are made so that the Carrier can once again satisfy its standard(s) for access to care.

Please confirm the carrier is aware of their responsibilities.

_____

(i) In tiered Networks and/or other instances where the Commissioner finds that cost-sharing levels could cause inadequate access to Provider types, Carriers shall provide at the Commissioner's request: a cost-sharing access analysis, illustrating the relationship between Providers at various cost-sharing levels and Insureds; or, for proposed plans or Service Areas, the relationship between Providers and the population, according to the Carrier's standard, for every city and town. For tiered Networks, the analysis shall indicate the relationship between Providers at each tier and associated cost-sharing level and Insureds; or, for proposed plans or Service Areas, the relationship between Providers and the population, according to the Carrier's standard, for every city and town.

Please confirm the carrier is aware of their responsibilities.

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211 CMR 52.12(3)

A Carrier shall make its selection standards for Participating Providers available for review by the Commissioner.

Confirm carrier will make available as noted above.

MATERIAL TO BE PROVIDED TO THE OFFICE OF PATIENT PROTECTION

211 CMR 52.16(1)

A Carrier shall provide the following to the Office of Patient Protection at the same time the Carrier provides such material to the Bureau of Managed Care:

a) A copy of every Evidence of Coverage and amendments thereto offered by the Carrier.
b) A copy of the Provider directory described in 211 CMR 52.15.
c) A copy of the materials specified in 211 CMR 52.14.

211 CMR 52.16(2)

A Carrier shall provide the following to the Office of Patient Protection by no later than April 1st:

(a) A list of sources of independently published information assessing Insured satisfaction and evaluating the quality of Health Care Services offered by the Carrier.

(b) A report of the percentage of physicians and Nurse Practitioners and Physician Assistants who voluntarily and involuntarily terminated participation contracts with the Carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Provider disenrollment;

1. For the purposes of 211 CMR 52.16(2)(b), Carriers shall exclude physicians, Nurse Practitioners, and Physician Assistants who have moved from one physician and/or Nurse Practitioner or Physician Assistant group to another but are still under contract with the Carrier.
2. For the purposes of 211 CMR 52.16(2)(b) "voluntarily terminated" means that the physician, Nurse Practitioner, or Physician Assistant terminated the contract with the Carrier.
3. For the purposes of 211 CMR 52.16(2)(b) "involuntarily terminated" means that the Carrier terminated its contract with the physician, Nurse Practitioner, or Physician Assistant;

(c) The percentage of premium revenue expended by the Carrier for Health Care Services provided to Insureds for the most recent year for which information is available;

(d) A report detailing, for the previous calendar year, the total number of:

1. filed Grievances, Grievances that were approved internally, Grievances that were denied internally, and Grievances that were withdrawn before resolution; and
2. external appeals pursued after exhausting the internal Grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such Insureds, which shall include, but need not be limited to, race, gender and age; and

(e) A report detailing for the previous calendar year the total number of:

1. medical or surgical claims submitted to the carrier;
2. medical or surgical claims denied by the carrier;
3. mental health or substance use disorder claims submitted to the carrier;
4. mental health or substance use disorder claims denied by the carrier; and
5. medical or surgical claims and mental health or substance use disorder claims denied by the carrier because:
   a. the insured failed to obtain pre-treatment authorization or referral for services;
   b. the service was not medically necessary;

c. the service was experimental or investigational;
d. the insured was not covered or eligible for benefits at the time services occurred;
e. the carrier does not cover the service or the provider under the insured's plan;
f. duplicate claims had been submitted;
g. incomplete claims had been submitted;
h. coding errors had occurred; or
i. of any other specified reason.

(f) A Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have meet the requirements of 211 CMR 52.16(1)(a) through (c) and (2)(c) through (e).

Please confirm the carrier complies with the above-noted requirements.

Fully Insured Student Health Plans Offered Within Massachusetts

BULLETIN 2016-06 July 6, 2016

As stated within the Bulletin, "[c]arriers are reminded that they must comply with all relevant federal requirements when issuing or renewing student health plan coverage in Massachusetts. As noted in federal guidance, Carriers must ensure that they only issue or renew student health plan coverage that:

- satisfies Centers for Medicare & Medicaid Services ("CMS") actuarial value requirements for individual health plans;
- meets Essential Health Benefits requirements for Massachusetts; and
- satisfies all federal rating rules for Massachusetts offered plans.

For further information regarding federal requirements for student health plans, see CMS-9981–F, *Student Health Insurance Coverage*, issued on March 21, 2012, and CMS-9972-F, *Patient Protection and Affordable Care Act: Health Insurance Market Rules; Rate Review*, issued February 27, 2013, at page 13424, as well as associated guidances.

Carriers are also reminded about guidance issued by CMS regarding rate review for student health plans, including guidance most recently issued on February 29, 2016. The Division reminds Carriers that they are to make all appropriate filings as described in such guidance. The Division expects that Carriers will submit the materials required by CMS.

In addition, Carriers **shall submit the following materials to the Division via the SERFF system as soon as practical after July 1 for plans with effective dates beginning on or after July 1 of the same year**:

1. A screenshot of the federal Actuarial Value Calculator printout that illustrates the actuarial value for the plan.
2. A copy of documents used to summarize the terms of coverage that disclose the actuarial value of the coverage and the "metal level" or next lowest metal level which the coverage would satisfy if the plan's actuarial value falls outside the actuarial value ranges for metal levels.
3. An actuarial certification stating how the plans:
   - satisfy CMS actuarial value requirements for individual health plans;
   - meet Essential Health Benefits requirements for Massachusetts;
   - satisfy federal rating rules for Massachusetts.

Forward the appropriate information, if applicable, and document where within the submission this information may be lcated.

SMALL GROUP PRODUCTS [M.G.L. c. 176J and regulation 211 CMR 66.00]

Please confirm whether the filed plan is intended to be offered to individuals or groups with between one and fifty eligible employees.
YES☐ NO☐

If NO, please provide the legal basis why the filed plan is not subject to the above-noted statute and regulation within your cover letter.

If YES, please review Massachusetts small group law M.G.L. c. 176J and regulation 211 CMR 66.00 including guaranteed issue and guaranteed renewal requirements. Please review that law and include provisions as required. In addition, please identify the section(s) and page number(s) of the documents filed that address the following issues:

DEFINITIONS [M.G.L. c. 176J §1]

Pg#_____ "Affordable Care Act", the federal Patient Protection and Affordable Care Act, Public Law 111-148, adopted March 23, 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and federal regulations adopted pursuant to that act.

Pg#_____ "Benefit level", the health benefits, including the benefit payment structure or service delivery and network, provided by a health benefit plan.

Pg#_____ "Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

Pg#_____ "Catastrophic plan", a health benefits plan limited exclusively for sale to eligible individuals who also meet the requirements of eligibility for catastrophic plans as defined in 42 U.S.C. § 18022(e) with premium rates that are consistent with section 3.
"Class of business", all or a distinct grouping of eligible insureds as shown on the records of the carrier which is provided with a health benefit plan through a health care delivery system operating under a license distinct from that of another grouping.

Pg#_____ "Connector", the commonwealth health insurance connector, established by chapter 176Q.

Pg#_____ "Connector seal of approval", the approval given by the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value.

Pg#_____ "Creditable coverage", coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public

health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (*l*) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

Pg#_____ "Date of enrollment", with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Pg#_____ "Eligible child", an eligible individual who, as of the beginning of a plan year, has not attained the age of 21 and who is seeking to enroll in a child-only plan offered by a carrier.

Pg#_____ "Eligible employee", an employee who: (1) works on a full-time basis with a normal work week of thirty or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business but does not include an employee who works on a temporary or substitute basis, and (2) is hired to work for a period of not less than five months.

Pg#_____ "Eligible dependent", the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child's twenty-sixth year of age.

Pg#_____ "Eligible individual", an individual who is a resident of the commonwealth.

Pg#_____ "Eligible small business" or "group", any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year employed from among one to not more than fifty eligible employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a MEWA shall be subject to this chapter.

Pg#_____ "Emergency services", services to treat 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 an insured or another 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)(l)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(l)(B).

Pg#_____ "Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; and an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G. Health benefit plans shall not include: accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies that provide a benefit to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, that are sold as a supplement and not as a substitute for a health benefit plan and that meet any requirements set by the commissioner by regulation; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; travel insurance; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. Travel insurance for the purpose of this chapter is insurance coverage for personal risks incident to planned travel, including but not limited to: (i) interruption or cancellation of trip or event; (ii) loss of baggage or personal effects; (iii) damages to accommodations or rental vehicles; or (iv) sickness, accident, disability or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverages. The term, "travel insurance" shall not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including for example, those working overseas as an ex-patriot or military personnel being deployed. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

Pg#_____ "Intermediary", a chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, as determined by the commissioner, which offers as a service to its members the option of purchasing a health benefit plan.

Pg#_____ "Qualified association", a Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and dependents of a prospective association member.

Pg#_____ "Qualifying health plan", any (i) blanket or general policy of medical, surgical or hospital

insurance described in subdivision (A), (C) or (D) of section one hundred and ten of chapter one hundred and seventy-five; (ii) policy of accident or sickness insurance as described in section one hundred and eight of chapter one hundred and seventy-five which provides hospital or surgical expense coverage; (iii) nongroup or group hospital or medical service plan issued by a non-profit hospital or medical service corporation under chapters one hundred and seventy-six A and one hundred and seventy-six B; (iv) nongroup or group health maintenance contract issued by a health maintenance organization under chapter one hundred and seventy-six G; (v) insured group health benefit plan that includes a preferred provider arrangement under chapter one hundred and seventy-six *I*; (vi) self-insured or self-funded employer group health plan; (vii) health coverage provided to persons serving in the armed forces of the United States; or (viii) medical assistance provided under chapter one hundred and eighteen E. The commissioner may, by regulation, define other health coverage as a qualifying health plan for the purposes of this chapter.

Pg#_____ "Resident", a natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident.

Pg#_____ "Wellness program", or "health management program", an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

GUARANTEE ISSUE/GUARANTEE RENEWABLE

Pg#_____ Section 4. (a)(1) Every carrier shall make available to every eligible individual and every small business, including an eligible small group or eligible individual, a certificate that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, and their eligible dependents, every health benefit plan that it provides to any other eligible individual or eligible small business. No health plan shall be offered to an eligible individual or an eligible small business unless it complies with this chapter. Upon the request of an eligible small business or an eligible individual, a carrier shall provide that group or individual with a price for every health benefit plan that it provides to any eligible small business or eligible individual. Except under the conditions set forth in paragraph (2) of subsection (b), each carrier shall enroll any eligible small business or eligible individual which seeks to enroll in a health benefit plan. Each carrier shall permit each eligible small business group to enroll all eligible employees and all eligible dependents; provided, however, that the commissioner shall promulgate regulations which limit the circumstances under which coverage shall be required to be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than when such eligible employee was initially eligible to enroll in a group plan. Notwithstanding the foregoing, this section shall not apply to health benefit plans sold exclusively as child-only plans or catastrophic plans.

Pg#_____ (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible individuals, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg?41(b), into a health plan if those individuals request coverage within 63 days of termination of any prior creditable coverage. A carrier shall also enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act, Public Law 111?148, and any rules, regulations and guidances applicable thereto, as amended

from time to time. A carrier shall enable any such eligible individual to renew coverage if that coverage is available to other eligible individuals. Coverage shall become effective in accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time, subject to reasonable verification of eligibility, and shall be effective through December 31 of that same year. Carriers shall notify any such eligible individuals that:

(i) coverage shall be in effect only through December 31 of the year of enrollment;

(ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of-pocket maximum, an explanation of how that deductible or out-of-pocket maximum and premiums will be impacted for the period between the plan effective date and December 31 of the enrollment year; and

(iii) the next open enrollment period during which any such eligible individual shall have the opportunity to enroll in a health plan that will begin on January 1 of the following calendar year.

A carrier shall not impose a pre-existing condition exclusion or waiting period of any duration on a health plan.

Pg#_____ (3) Notwithstanding paragraph (2), a carrier shall only enroll an eligible individual, as defined in said paragraph (2) who does not meet the requirements of said paragraph (2) into a health plan during the annual open enrollment period for eligible individuals and their dependents. The open enrollment period shall be from October 15 to December 7, inclusive, unless otherwise designated by the commissioner and coverage shall begin on January 1 of the following year.

Pg#_____ (4) Notwithstanding this section or any other general or special law to the contrary, the office of patient protection may administer and grant enrollment waivers to permit enrollment not during a mandatory open enrollment period to the extent permitted under the federal Patient Protection and Affordable Care Act, or any rules, regulations or guidances applicable thereto, and in accordance with chapter 6D and any other applicable laws.

Pg#_____ (b)(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the commissioner of insurance when such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg?12; provided, however, that cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the commissioner of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

Pg#_____ (2) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has

repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

Pg#_____ (3) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that:

(i) the small business fails at the time of issuance or renewal to meet a participation requirement established under the definition of participation rate in section 1; or

(ii) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner.

Pg#_____ (4) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or an eligible small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or eligible small business enrolls through an intermediary or the connector. If an eligible individual or an eligible small business with 5 or fewer eligible employees elects to enroll through an intermediary or the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all similarly situated eligible individuals and eligible small businesses in a similar manner.

Pg#_____ (5) Notwithstanding any other provision in this section, with respect to a health benefit plan offered only through a public exchange that pursuant to federal law and regulation does not include pediatric dental benefits, a carrier may deny an eligible individual or eligible small business of any size enrollment in such health benefit plan unless the eligible individual or eligible small business enrolls through the connector. If an eligible individual or eligible small business elects to enroll through the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all eligible individuals and eligible small business in a similar manner.

Pg#_____ (c)(1) Every health benefit plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996 as amended, or by regulations promulgated under that act.

Pg#_____ (2) A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (i) has not paid the required premiums; (ii) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; (iii) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; (iv) fails, at the time of renewal, to meet the participation requirements of the plan; (v) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (vi) in the case of a group, is not actively engaged in business.

Pg#_____ (3) A carrier may refuse to renew enrollment for an eligible individual, eligible employee or eligible dependent if: (i) the eligible individual, eligible employee or eligible dependent has committed fraud, misrepresented whether or not he or she is an eligible individual, eligible employee or eligible dependent, or misrepresented information necessary to determine his eligibility for a health benefit plan or for specific health benefits; or (ii) the eligible individual, eligible employee or eligible dependent fails to comply in a material manner with health benefit plan provisions.

Pg#_____ (d) Nothing in this chapter shall prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the definition of eligible employee.

ANNUAL ACTUARIAL OPINION [M.G.L. c. 176J §7]:

According to M.G.L. c. 176J §7(a)2, "[e]very carrier shall make reasonable disclosure to prospective small business insureds, as part of its solicitation and sales material of...(2) the participation requirements or participation rate adjustments of the carrier for each health benefit plan.

Please confirm that the carrier will comply with this requirement.

INDIVIDUAL PROTECTIONS –

APPLICATION FORM - Application form must conform to requirements of M.G.L. c. 175I:
Please confirm that the carrier is in compliance with M.G.L. c. 175I as well as the Federal HIPAA Privacy Notice [Title 45 of the Code of Federal Regulations ("CFR") Parts 160 and 164].

Form and Content of Policy Applications – [211 CMR 40.13]:
When a person uses an application form to be completed by the applicant as an offer to contract for an insured health plan, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with 211 CMR 40.13 the following guidelines as to the contents and applicability of disclosure requirements shall be used.

pg____ 1. If the advertised or marketed policy contains a provision which allows the carrier to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy, the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in 211 CMR 40.07(3)(a).

[Pre-Existing Conditions - 211 CMR 40.07(3)(a).
A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used or it shall be considered misleading, and therefore prohibited.]

pg____ 2. If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind, *e.g*. "fifth day for sickness" or of the one-time exclusionary kind, "30 day" or "six months for certain conditions," the application must disclose in negative terms the nature of such exclusion.

pg____ 3. The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

pg____ 4. The application must disclose the premium rate for the policy being solicited.

pg____ 5. The application must disclose clearly and unambiguously the terms of renewability and premium guarantee, if any.

pg____ At the completion of the above required statements of disclosure space shall be made for the applicant's signature acknowledging understanding of such disclosures.