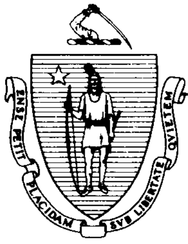

The Commonwealth of Massachusetts

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To: Commercial Health Insurers, Blue Cross Blue Shield of Massachusetts, and Health Maintenance Organizations Accredited Pursuant to M.G.L. c. 176O

From: Carol Balulescu, Deputy General Counsel

Re: Emergency Amendments to 105 CMR 128.000, *Health Insurance Consumer Protection*

Date: September 15, 2011

The purpose of this memorandum is to advise you of emergency amendments to 105 CMR 128.000, *Health Insurance Consumer Protection*, which will require immediate changes to health plan procedures and consumer disclosures.

As you know, the federal Affordable Care Act ("ACA") imposes many new requirements on insured health plans, including the requirement that all plans provide the opportunity for external review of an adverse determination. The ACA permits the continued operation of a state process for carriers subject to state law if the state process meets or exceeds the consumer protections in the National Association of Insurance Commissioners ("NAIC") Uniform External Review Model Act. In addition, until January 1, 2014, a state may operate an external review process under federal standards similar to the required consumer protections, which were identified in guidance issued in June of 2011.

The Massachusetts external review process set forth in M.G.L. c. 176O and 105 CMR 128.000 ("the Office of Patient Protection or OPP external review process") did not meet the original federal standards or the recently-issued similar standards. The Department's Public Health Council approved emergency amendments to 105 CMR 128.000 on September 14, 2011, which will meet the NAIC-similar standards and enable the OPP external review process to continue at least until January 1, 2014. The emergency amendments appear as pages 3 and 4 of this memorandum.

The amendments make the following changes to 105 CMR 128.000:

- Insureds will now have four months to file an external review.
- Insureds do not have to exhaust the internal appeal process before filing an expedited external review – an insured may file an expedited external review at the same time as he files an expedited internal appeal request.
- Standard external reviews must be completed within 60 calendar days and expedited external reviews must be completed within four business days.

OPP has amended its external review request form to reflect these changes, which can be found on its website at http://www.mass.gov/Eeohhs2/docs/dph/patient_protection/external_review_form.pdf.

In order to comply with the new amendments, carriers must make the following changes:

- Carriers must **immediately** amend all consumer disclosures, including letters, to indicate the changes in timelines noted above.
- Carriers must advise any insured or authorized representative who requests an expedited internal review that they are eligible to request an expedited external review at the same time and must provide them with a copy of the external review request form.
- Carriers must provide the revised external review form with all final adverse determinations.

If you have any questions about this memorandum, please contact me at 617-624-5216 or carol.balulescu@state.ma.us.

Emergency Amendments to 105 CMR 128.000

128.400: External Review

Any insured or authorized representative of an insured who is aggrieved by a final adverse determination issued by a carrier or utilization review organization may request an external review by filing a request in writing with the Office of Patient Protection within ~~45 days~~ four months of the insured's receipt of written notice of the final adverse determination.

128.405: Screening of Requests

(A) The Office of Patient Protection shall screen all requests for external reviews to determine if they:
- (1) comply with the requirements of 105 CMR 128.404;
- (2) do not involve a service or benefit that has been explicitly excluded from coverage by the carrier in its evidence of coverage; and
- (3) result from a carrier's issuance of a notice of final adverse determination~~,~~ provided, however, that no final adverse determination is necessary where the carrier has failed to comply with timelines for the internal appeal process or if the insured or his or her authorized representative is requesting an expedited external appeal at the same time that he or she is requesting an expedited internal appeal.

(B) Screening of requests for expedited reviews shall begin within 48 hours of receipt. Screening of all other requests shall begin within five business days of receipt.

128.415: Decisions and Notice

(A) The external review agency shall determine whether the service that is the subject of the review is medically necessary and is a covered benefit as defined in 105 CMR 128.020.

(B) The final decision of the external review agency shall be in writing and set forth the specific medical and scientific reasons for the decision and shall be furnished to the insured, or where applicable the insured's authorized representative, and the carrier.

(C) For non-expedited reviews, an external review agency shall issue its final disposition within 60 ~~business~~ calendar days from its receipt of the referral from the Office of Patient Protection. ~~If the review agency determines that additional time to fully and fairly evaluate the request for review is required:~~
- ~~(1) it may extend the time period for issuing a disposition for an additional period not to exceed 15 business days; and,~~
- ~~(2) shall provide notice of any said extension to the insured and the carrier or utilization review organization.~~

(D) For expedited reviews, the external review agency shall issue its final disposition within ~~five~~ four business days from its receipt of the referral from the Office of Patient Protection.

(E) Nothing herein shall prohibit the parties from voluntarily proceeding with any informal efforts to resolve the matter under review prior to the issuance of a final decision.

(F) The decision of the external review agency shall be binding.

(G) If the external review agency overturns a carrier's decision in whole or in part, the carrier shall issue a written notice to the insured within five business days of receipt of the written decision from the review agency. Such notice shall:

(1) acknowledge the decision of the review agency;
(2) advise the insured of any additional procedures for obtaining the requested coverage or services;
(3) advise the insured of the date by which the payment will be made or the authorization for services will be issued by the carrier or utilization review organization; and
(4) advise the insured of the name and phone number of the person at the carrier who will assist the insured with final resolution of the grievance.